DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2009 BUDGET

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2009 BUDGET

WEDNESDAY, FEBRUARY 27, 2008

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The Committee met, pursuant to call, at 2:00 p.m., in room 210, Cannon House Office Building, Hon. John M. Spratt [Chairman of the Committee] presiding.

Present: Representatives Spratt, Allen, Schwartz, Doggett, Scott, Etheridge, Ryan, Garrett, Hensarling, Conaway, Smith, and Jordan.

Chairman SPRATT. This hearing is on the 2009 budget request for the Department of Health and Human Services. This hearing gives us an opportunity for members to explore the President's budget request for HHS in greater detail. I would like to thank Secretary Leavitt for appearing before the Committee today and not only that, for accommodating our schedule change so that he could be at the hearing. We appreciate your coming again and look forward to your testimony.

The HHS budget should be considered in the broader context of the President's 2009 budget which continues its same policies as the previous years, but with more dramatic affects. To help pay for the nearly $2 trillion in tax cuts over the next ten years, the budget cuts Medicare by $556 billion over ten years, more than double the cuts included in last year's budget. It also assumes legislative and regulatory cuts to Medicaid totaling $81 billion over the same period of ten years. These cuts will harm State's ability to serve the uninsured, at the same time they are experiencing budget shortfalls due to their own circumstances.

The budget for HHS also cuts or freezes vitally important public health programs that are essential to increasing access for the under served or making advances in medical research that lead to improvements in health. The budget includes cuts to several safety net programs which are vital to supporting struggling working families, such as, LIHEAP, the low-income energy assistance program and SSBG, the Social Services Block Grant. These cuts will harm millions at the worst possible time just when our economy is on the edge of recession; just when employment is declining and Americans are depending most on these programs.

We recognize the long-term challenges facing the budget. It is important, however, to keep in mind that this Administration has aggravated those challenges through it's policies, mainly large tax cuts resulting in the largest tax deficits in history. These deficits

have led to a moratorium of debt that prevents resources. A mountain of debt, excuse me, I wish it was a moratorium. A mountain of debt that prevents resources from being used for other priorities.

It is also worth noting that while the Administration has focused a great deal of time and energy on privatizing Social Security, that the President signed into law the Medicare Modernization Act of 2003 which created an even larger unfunded obligation than that of Social Security. As we consider the problems facing the federal budget, we should keep in mind that Medicare and Medicaid are experiencing the same challenges facing the health care sector, notably the rise in excess cost growth.

Cutting Medicare and Medicaid to meet budget targets alone without addressing the underlying structural causes of excess spending growth, we fear will only lead either to shifting cost to other sectors or to putting beneficiaries at risk. Earlier this month Congress received the Administration's Medicare proposal to address the trustees Medicare funding warning. We are eager to learn more about this proposal and whether or not it would result in cost shifts and actually address the issue of cost growth in the health care delivery sector.

The challenges ahead of us are tremendous, and we appreciate Secretary Leavitt's presence to help us understand the Administration's views and his own views on these particular issues. But before turning to the Secretary for his testimony, I want to recognize the Ranking Member Mr. Ryan for any comments that he may care to make. Mr. Ryan.

[The prepared statement of Chairman Spratt follows:]

PREPARED STATEMENT OF HON. JOHN M. SPRATT, JR., CHAIRMAN, HOUSE COMMITTEE ON THE BUDGET

Good afternoon, and welcome to the House Budget Committee's hearing on the 2009 budget request for the Department of Health and Human Services. This hearing provides an opportunity for members to explore the President's budget request for HHS in greater detail. I would like to thank Secretary Leavitt for appearing before the committee today and accommodating our schedule change for this hearing. We appreciate you coming and look forward to your testimony.

The HHS budget should be considered in the broader context of the President's 2009 budget, which continues the same policies as previous years but with more harmful effects. To help pay for nearly $2 trillion in tax cuts over the next ten years, the budget cuts Medicare by $556 billion, more than double the cuts included in last year's budget. It also assumes both legislative and regulatory cuts to Medicaid totaling $81 billion over the same time period. These cuts will harm states' ability to serve the uninsured at the same time they are experiencing budget shortfalls due to the economic slowdown. The HHS budget also cuts or freezes important public health programs that are vital to increasing access for the underserved or making advances in medical research that lead to improvements in health. As significant, the budget includes cuts to several safety-net programs that are vital to supporting struggling working families, such as the Low Income Home Energy Assistance Program (LIHEAP) and the Social Services Block Grant (SSBG). These cuts will harm millions at a time when they depend on these programs the most, particularly during this time of economic uncertainty.

We recognize the long-term challenges facing the budget. It is important, however, to keep in mind that this Administration has compounded these challenges through policies resulting in the largest deficits in American history. These deficits have led to a mountain of debt that prevents resources from being used for other priorities. It is also worth noting that while the Administration focused a great deal of time and energy on privatizing Social Security the President signed into law the Medicare Modernization Act of 2003, which created an even larger unfunded obligation than that of Social Security. As we consider the problems facing the Federal budget, we should keep in mind that Medicare and Medicaid are experiencing the same

challenges facing the health care sector, notably the rise in excess cost growth. Cutting Medicare and Medicaid to meet budget targets, without addressing the underlying causes of excess spending growth, will only serve to either shift costs to other sectors or to put beneficiaries at risk of losing access to necessary care. Earlier this month, Congress received the Administration's Medicare proposal to address the Trustees Medicare funding warning. We are eager to learn more about this proposal and whether it would result in cost shifts or actually address the excess cost growth of the health care sector.

The challenges ahead are significant, and we appreciate Secretary Leavitt's presence to help us understand the Administration's views on these issues. Before turning to the Secretary for his testimony, I recognize the Ranking Member, Mr. Ryan, for any comments he may wish to make.

Mr. RYAN. Thank you very much, Chairman. Welcome back again to the Committee, Secretary Leavitt. When you testified to this Committee last year, one of the important points you made was this: You said that we do not have a health care system in this country, that we have a health care sector. It is concept you repeated at the Ways and Means Committee, which I serve on, just recently as well. And you said that health care should be, "* * * a private market where consumers chose, where insurance plans compete, and where innovation drives the quality of health care up and may drive the cost down." And that principle as I understand it, underlies much of the Administration's approach to health care including the President's health tax proposal.

This is important, because it goes right to the heart of the health care debate. If there are problems with health care they do not, they have not come about not because the market has failed, but because of distortions imposed upon it over the decades. Those who think they can fix health care with more government spending and intervention, I believe, are headed in the wrong direction, and consumers and patients will suffer for it.

Let me just cite two examples, both of are which are relevant to the budget we are considering. First is health insurance. Most people in America who have health insurance get it from their employers or the government, that is from third parties. And this is mainly because of an accident of tax law that goes back to World War II when there were wage and price controls. What is odd is that we don't expect somebody else to chose our cars or refrigerators or our clothes for us, but with something as important as health insurance we do. It is no wonder some people get frustrated about their coverage or feel in danger of losing it. They are not calling the shots.

Second is government spending. About 35 percent of the $2 trillion we spend on all health care nationally comes from two government programs; Medicare and Medicaid. When government pours that much money into any sector it is going to affect prices and distort the practice of medicine. In other words, one of the reasons health care costs are rising so rapidly is a huge amount of spending and distortion and control that the government pumps into it.

These programs also affect the benefits and pricing of private health insurance because they create benchmarks that commercial insurers fall back on too. The point is this: The key to both controlling health care cost and expanding coverage lies in removing the distortions in the market. That means several things including ownership. Health insurance should be owned by the people who use it. And we can accomplish this by shifting the current tax ben-

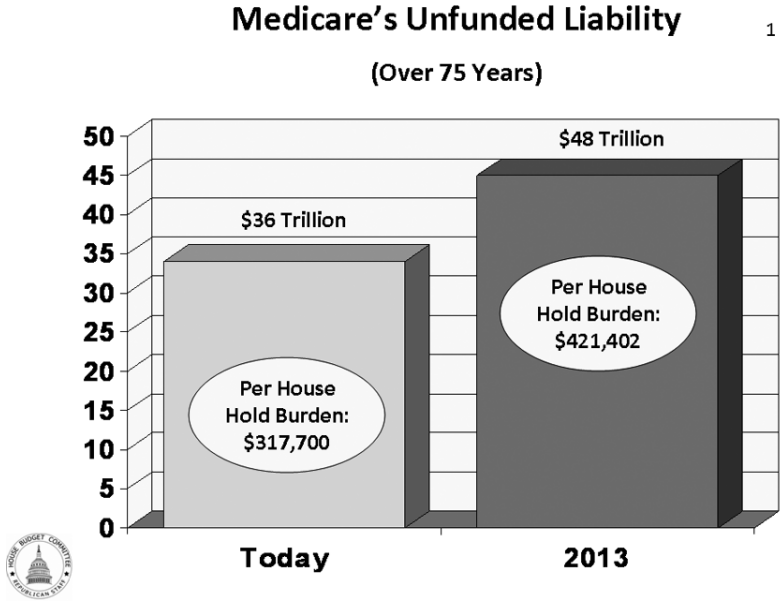
efit from employers to individuals and families so we are not discriminating against people who get it from their jobs only.

We can debate whether there should be a deduction or a credit or what have you, but the point is that it should be changed to personal ownership so you can move job to job with your health care.

Transparency. One of the big problems in health care is prices are opaque. In Milwaukee, I have done the research, you can pay anywhere from $47,000 to $100,000 for bypass surgery. Anywhere from $600 to $5,000 for an MRI and the same procedure at the same hospital, but most patients and sometimes even doctors don't even know this.

Entitlement reform. Something that is missing from nearly every major health care reform plan being discussed is that they don't include fundamental fixes in reforms to Medicare and Medicaid. As I indicated before, unless we reform those programs and moderate their unsustainable spending growth, they will continue adding to medical inflation and health care reform itself will fail.

The President's budget does address these issues. If you would pull up chart number 1, please.



Mr. RYAN. And it tries to foster a truer, more efficient marketplace. We may not agree with every specific proposal that the President offers, but he does point in an important direction that we ought to consider.

I look forward to discussing these issues here with you today and I also look forward to discussing the Medicare trigger. But before I conclude, let me simply say this: We are going to be marking up the budget resolution here next week. And if the budget resolution that comes to the floor does not include any reforms to the Medicare Program to save money, then we will be forced with adding the unfunded liability, which is today stands at Medicare at $34

trillion which is about $300,000 per household, to $45 trillion over just five years. That means if Congress neglects it's responsibility and it's duty to do something to save and rescue Medicare, we will add a debt that goes from $34 trillion today to $45 trillion for the time when my children need this program.

It is irresponsible of us to not take this action. So when I hear the word cut, the word cuts to Medicare as are in this budget, I simply look to the fact that under this President's budget, they are proposing to increase Medicare spending at five percent a year. If it goes up five percent from last year to the next year, that is not a cut. That is an increase of five percent.

And with that, I yield.

Chairman SPRATT. Mr. Secretary, thank you again for coming. We have your testimony which was pre-filed and we will make it part of the record so that you can summarize as you see fit.

I might mention that when you were last here and testified last year, we talked about program integrity funding and we put in our budget resolution, which passed, some substantial additional money for that very purpose in order to get at the problem of waste, fraud, and abuse in the programs under your jurisdiction. Unfortunately, that money was left on the cutting room floor when the budget was downsized at the President's insistence when we negotiated the omnibus for this year.

I would hope that we could do something next year, and we would like your testimony, if you could, as to how bad the problems are and what can be done with additional program integrity money.

STATEMENT OF HON. MICHAEL O. LEAVITT, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary LEAVITT. Thank you, Mr. Chairman. At our meeting last year I recounted experiencing that I had personally had going out with Office of Inspector General agents, particularly in Southern Florida where I saw first hand fraud and abuse. I saw office buildings full of what were very clearly shell businesses that had been established solely for the purpose of defrauding the American people and Medicare beneficiaries.

Essentially they work in the same way. They set these up, they get a billing number in the same office building. They are able to find someone who can rent them names and lists who can in fact then begin to bill enough claims against Medicare that in a course of four or five months they can collect and then close down and leave. And they do it over and over and over again.

I think I may have related the story last year where the week I was there the Inspector General agents had been able to procure access to three or four of the front people, not the people behind them, but they were able to get them to empty their bank accounts out. And they held checks for $10 million where they had simply written checks to clear the accounts out. We are talking about hundreds of millions, billions of dollars.

You were very gracious last year in this Committee in being able to designate about $300 million plus for that purpose. This money pays dividends in multiples. I am talking about four, five, six, ten times the amount we spend we get back. I am appreciative of the

chance to reinforce that and we hope very much that that could be considered in this budget. It just needs to happen. Every year we don't do it, money is going out the door. It continues.

We have done a number of things in the meantime. We have changed or changing we are in the process, for example, requiring those who put durable medical equipment out in certain areas have to post bonds. We are essentially making everyone re-qualify. We are doing everything with the resources that we have and we are having some impact, but we need additional resources so we can do it other areas.

I have posted my statement. I won't review it, other than to just say three things: The first is we have this budget is very clearly directed at trying to balance the budget, trying to sustain and put entitlements into a sustainable place. And to make certain that premiums are affordable to beneficiaries.

I have grave concerns for all of the reasons that have been spoken already by Mr. Ryan. Medicare warnings have just become a seasonal thing. They come and they go like the cherry blossoms and when they happen we all stop, pause, and say that is a serious problem and then move on without taking action. I hope this budget will at least be viewed as a warning.

Every year, every year, whoever sits in my chair, whoever sits in your chair all the money is going to have to deal with this until we do. And they will be facing the same kinds of issues that I have raised in this budget. I have gone through and done the best I could to find ways in which you could make the budget balance. I would suggest this is not reform. What this is, is a budget. It is a budget just doing the best I can and what I think is a broken system. This is a government regulated, price setting, centrally planned system and it will always produce choices that won't reflect a solution. And so I am hopeful that in the course of this that the budget well, it will make a lot of people unhappy, at least it will raise the one more warning that we have to deal with this.

Now I recognize that there is a need to come up with a solution. And hopefully we will get to talk about solutions. I believe many of the same things Mr. Ryan said earlier, and that is the need for us to make Medicare more about educated consumers. And when we do, I believe, there is a means by which we can begin to turn the tide on this and create a true system.

I know there will be lots of questions and so rather than take more of that time, Mr. Chairman, I will just yield whatever time I have left back, and lets go to the questions.

[The prepared statement of Michael O. Leavitt follows:]

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Prepared Statement of Hon. Michael O. Leavitt, Secretary,
U.S. Department of Health and Human Services

Chairman Spratt, Congressman Ryan, and Members of the Committee, thank you for the invitation to discuss the President's FY 2009 budget request for the Department of Health and Human Services (HHS).

I wish to begin with Medicare, which makes up 56 percent of the $737 billion budget HHS presents today.

The Medicare portion of this budget should be viewed as a stark warning. Medicare, on its current course, is not sustainable. In 2007, the Medicare Trustees reported the Hospital Insurance Trust Fund will be exhausted in 2019 -- 11 years from now – and Medicare represents a $34.2 trillion unfunded obligation for the federal budget over 75 years. This is a serious matter.

Let's acknowledge that American sensitivity to entitlement warnings has become numbed by a repeated cycle of alarms and inaction. Such warnings have become a seasonal occurrence, like the cherry blossoms blooming in April, part of life's natural rhythm. We hear the warnings, but do nothing

This budget warns in a different way. It illuminates with specificity the hard decisions policy makers, no matter what their party, will face every year until we change the underlying philosophy. We can keep our national commitment to insuring the health of beneficiaries, but we need a change in how we manage Medicare.

Currently, the Medicare fee-for-service program is a centrally-planned, government regulated system of price setting. Price setting systems allow government regulators to decide the priorities.

Government's tools are blunt and inexact. Government decides which treatment to cover. Government decides how much treatment is provided based on how much government is willing to pay for. Government tries to determine how much value different procedures have. It is a bad system and needs to be changed.

If consumers were allowed to make these decisions through an efficient and transparent market, their decisions would be far more precise and wise.

One need look no further than our experience with Medicare's prescription drug benefit, where government organized a market and let consumers decide what drug plan worked best for them. Entering the third year of the program, we see enrollment continuing to rise, beneficiary satisfaction extremely high, and costs to beneficiaries and taxpayers considerably lower than originally projected.

Just last month we announced that, compared to original Medicare Modernization Act (MMA) projections, the projected net Medicare cost of the drug benefit is $243.7 billion lower over the 10-year period (2004-2013) used to score the MMA. Beneficiaries are saving as well. The most recent CMS estimate of the actual average premium beneficiaries will pay for standard Part D coverage in 2008 is roughly $25. This is nearly 40 percent lower than originally projected when the benefit was established in 2003.

While there are several important factors that contribute to lower costs, a key factor is that competition has been strong from the beginning of the program and the plans have achieved greater than expected savings from retail price negotiations, manufacturer rebates, and utilization management.

That said, however, using the blunt instruments we have available to us in other parts of Medicare, we have prepared a budget with three goals in mind: long term sustainability, affordable premiums for beneficiaries and a balanced national budget by 2012.

Some will be unhappy with this budget. While Medicare spending will increase by an average of 5 percent annually under our budget, they will see any attempt to slow the rate of Medicare's growth as a cut.

Our proposed budget includes a group of legislative and administrative improvements aimed at extending Medicare's viability for today's seniors and future generations. The slower growth rate they produce saves $183 billion over five years.

The proposals include:

- Encouraging provider competition and efficiency
- Promoting high quality care
- Rationalizing payment policies
- Improving program integrity
- Increasing high-income beneficiary responsibility for health care costs

The slower growth rate also reduces the premiums beneficiaries face by $6.2 billion over the next five years. Let me emphasize that generally, changes we make that reduce future government spending also give a financial break to beneficiaries.

I mentioned Medicare warnings earlier. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress included a provision requiring the Medicare Trustees to issue a formal warning if two consecutive annual reports show that regular tax dollars exceed 45 percent of total Medicare spending within the current or next six years. I am a Trustee of the Medicare Trust Fund. Last year we triggered the alarm. As usual, there has been no action.

The same law calls for the President to propose legislation that will change the trajectory enough to bring general revenues back below 45 percent. The President believes it is important to respond to the 2007 warning about the future fiscal health of Medicare.

I was designated by the President as the official responsible for this response and on Friday, February 15, I submitted legislation to Congress.

This legislative package addresses the immediate problem identified by the 2007 warning and helps lay the foundation for transforming Medicare so it becomes a program based on the highest quality and the greatest value. This proposal should be enacted in conjunction with the Medicare savings in the 2009 budget, which addresses nearly one-third of the program's $34 trillion unfunded obligation.

The legislation we propose offers a three-step approach to the problem of unsustainable Medicare spending growth.

Title I provides the HHS Secretary with the authority and responsibility to introduce value-driven competition into the Medicare program. These principles are intended to reduce Medicare spending by increasing provider efficiency and helping beneficiaries to be wiser consumers. Specific elements in the legislation include:

- Adoption of health information technology, such as electronic medical records and e-prescribing;
- Transparent pricing information;
- Transparent quality information; and
- Incentives for providers to deliver and beneficiaries to choose high-quality, low-cost health care.

Title II of this legislation implements the President's medical liability reform agenda.

- The medical liability crisis has littered our courts with junk lawsuits. It has hindered patient care, resulting in 1500 counties lacking an Ob-Gyn. And it costs our health care system up to $100 billion per year.
- We need reform in order to have a rational medical liability system.

Finally, Title III reduces the Medicare premium subsidy for higher-income individuals in Part D.

- Income-relating the Part D premium was contained in the President's last two budget proposals.
- It will save over $900 million in 2013 and nearly $3.2 billion over five years.

Although this package responds to the funding warning identified in the 2007 report, more must be done to strengthen Medicare for the long-term.

I am eager to work with Congress to quickly pass this legislation – and the savings proposed in the President's Budget -- so we can get started on making Medicare a healthy program for current and future generations. But real solutions in Medicare will require genuine change in the way in which health care is conducted in America. And, if I can comment on that broader topic for a moment, let me say this:

There are two competing philosophies about the role government should play in health care. One is a Washington-run, government-owned plan, where government makes the choices, sets the prices, and then taxes people to pay the bill.

The other, supported by the Administration, is a private market where consumers choose, where insurance plans compete, and where innovation drives the quality of health care up and may drive the cost down.

The Administration believes every American needs access to health insurance at an affordable cost. In addition to its proposed tax reforms and health insurance market-based initiatives, the Administration believes the current health care system could operate more efficiently, without increasing federal spending on health care, if some portion of indirect public subsidies were redirected to make health insurance affordable for individuals with poor health or limited incomes. The federal government would maintain its commitment to the neediest and most vulnerable populations, while giving the States, which are best

situated to craft innovative solutions, the opportunity to move people into affordable insurance.

Before leaving Medicare, I want to make one more point.

I spoke earlier about the cherry blossom syndrome of entitlement warnings. Many may look at this budget and see the same old cherry blossom story – X billion of reductions here and Y billion there. But, as a Trustee of the Medicare Trust Fund, I ask that you concentrate on the condition of the Medicare Trust Fund. It is a story that needs to be told, and told, and told.

I have admired and appreciated David Walker, the Director of the Government Accountability Office (GAO) traveling the country sounding the warning. If my remarks today, describing the Department's budget, don't focus attention on this problem, then read his speech. Call the government actuary, or your favorite economist.

We are approaching an emergency. Real change in Medicare as a system is required, and soon. If you are 54 years old, and if Medicare is left on autopilot, when you turn 65 years old, Medicare will not be able to provide all the hospital insurance benefits promised under current law. We need a change in philosophy not just a change in the budget.

Now, on to other matters.

State Children's Insurance Program (SCHIP)

The President proposes to increase funding to states by $19.7 billion through 2013, with $450 million in outreach grants. Our proposal is consistent with the Administration's philosophy that SCHIP should be focused on uninsured, targeted, low income children first. It is also consistent with the position the President and the Administration articulated last fall. Our legislative proposal calls on Congress to address the issue of "crowd-out." It outlines State responsibilities when they expand SCHIP programs,

proposes enforcement mechanisms, and clarifies SCHIP eligibility by clearly defining income.

Medicaid

We are continuing our successful transformation of the Medicaid program. This budget request includes a series of proposed legislative and administrative changes. We propose legislative savings of more than $17 billion and assume administrative savings of approximately $800 million over the next five years while keeping Medicaid up-to-date and sustainable.

Food Protection

We have a good system of food protection in the United States, but as the global market matures, our systems have to change. Last year, we unveiled the Import Safety Action Plan and the Food Protection Plan which propose significant improvements in how we deal with imported products.

Our goals are to:

- Promote a common vision of import safety with our trading partners and foster a culture of collaboration;
- Focus on risks over the product life cycle rather than a snapshot at the border;
- Increase accountability, enforcement and deterrence with regard to imports;
- Build interoperable data systems and encourage data sharing; and,
- Promote technological innovation and develop new tools to enhance import safety.

The President's budget increases funding for food safety by $42.2 million or 7 percent, and the overall FDA budget by 5.7 percent. These increases for food safety will be used to continue implementing the prevention, intervention, and response measures of the Food Protection Plan.

Biomedical Research

We have proposed increases for each Institute and Center at NIH. The overall budget will support 38,000 research project grants, including more than 9,700 new and competing awards. Overall, the budget will be the same as FY 2008.

Emergency Preparedness

Our nation remains at risk of terrorist attack and war. HHS is responsible to prevent and detect attacks, and respond to mass casualty events. Our budget proposes $4.3 billion to:

- Increase bioterrorism readiness
- Double advanced development of medical countermeasures
- Establish new international quarantine stations
- Expand and train medical emergency teams

We are seeking the funds necessary to complete our Pandemic preparedness.

One rather interesting part of our preparedness budget deals with ventilators. In many emergencies, especially terrorist attacks or pandemics, ventilators are needed to help victims breathe. Currently, ventilators cost $8,000 to $10,000 each. They also require specially trained teams to operate them. The combination of those two factors makes having an adequate supply nearly impossible.

We are requesting $25 million to develop the next generation of ventilators that are portable, up to 90 percent less expensive and do not require special training to operate.

Health Information Technology

The President's budget proposes $66 million for the Office of the National Coordinator for Health Information Technology (ONC) to support activities coordinating federal, state and local government and private sector efforts to transition to an environment of electronic health information exchange. The budget will support ONC work to advance the President's goal for most Americans to have access to electronic health records (HER) by 2014 through:

- Establishing a successor to the American Health Information Community (AHIC) to an independent and sustainable public-private partnership;
- Determining, testing, and recognizing agreed upon health data standards;
- Working to remove barriers to create an environment that promotes the adoption and use of health IT;
- Investigating and supporting solutions for privacy and security challenges in electronic health information exchange;
- Implementing exchange of standardized test data among communities engaged in trial implementation activities to work towards the goal of the Nationwide Health Information Network.

Global Health

You will see a series of health diplomacy initiatives. Because threats to human health have become just as mobile as we are, our leadership in health around the world benefits Americans directly.

In addition to our work on HIV/AIDS, Malaria and Tuberculosis, we help other nations with disease monitoring and preparedness.

Conclusion

These are just some of the highlights of our budget proposal. Both the President and I believe that we have crafted a strong, fiscally responsible budget at a challenging time for the Federal government, with the need to further strengthen the economy and continue to protect the homeland.

We look forward to working with Congress, States, and all our other partners to carry out the initiatives President Bush is proposing to build a healthier, safer and more compassionate America.

Now, I will be happy to take a few questions.

Chairman SPRATT. Thank you, Mr. Secretary. One of the issues we have dealt with in the past year is Medicare Advantage, which was tucked away in the back titles of the Medicare Modernization Act, which primarily dealt with the addition of a prescription drug benefit to the Medicare Program.

CBO has told us that the differential on average in payments per beneficiary under Medicare Advantage as opposed to traditional fee for service Medicare is 13 percent. In other words, this program Medicare Advantage, which was intended to be a managed care option for Medicare and to therefore to save money, instead it is costing us more money than traditional fee for service medicare.

Number one, do you disagree with that? And number two, have you seen the particular graph that was published by the CBO

which shows that given the differential today and the likely growth of this program, because it is better funded, that the cost of providing for care of beneficiaries under this program over tens years is likely to be $150 billion more than fee for service beneficiaries?

Secretary LEAVITT. I am aware. I was not here in 2003, but I am aware that the Congress made a decision to expand the program on a countrywide basis. And that they established the pricing in a way that would accomplish that. I am also aware that they chose to have that additional pricing reflected in benefits and that it has clearly worked. And that people are happy with it and that they are in fact enrolling in large numbers and that we have now accomplished some 20 percent who of the beneficiaries who have chosen it.

I am also aware that those who enroll not only are they happy because of the additional benefits, but because they are having an easier time getting a physician. Now do I think it is perfect? No, I don't. But I think it is a very positive move toward the kind of thing I spoke of earlier.

I have indicated in other testimony that I believe there are some things we can do to refine it where the actual bidding that goes on is done in broader areas and we will begin to see competition drive the cost of it not just down to where it is now, but perhaps lower. I think we are on the right track we just need to continue to work and refine it in ways that will allow the market to work and for consumers to have the chose that they——

Chairman SPRATT. Well do you plan in the near term to equalize the cost between the two programs or at least to remove this 13 percent, 14, 15 percent advantage?

Secretary LEAVITT. I—well, again, I want to acknowledge the fact that these additional, this additional amount is going into benefits for beneficiaries. I think we can probably concur with that.

I also believe it does need to be allowed to make certain we have a fully implemented national program. I also believe that if in fact we were to expand and refine the bidding process that we will see a market begin to not only drive it down to where it is equal with existing rates, but below. I think we can see it not only come to the point that it is equalized, but go below, because I believe that is the power of the market that it will unleash.

Chairman SPRATT. In your quest for program integrity, and I commend you for that, have you encountered waste, fraud, and abuse in the marketing of Medicare Advantage policies?

Secretary LEAVITT. Yes, we have.

Chairman SPRATT. Would you care to elaborate on that?

Secretary LEAVITT. Well it exists. And we are doing everything we can to just like we are in other areas to remedy that. And, unfortunately, when any program of this nature and I am not talking just about Medicare Advantage, I am talking about Medicare, we have to be vigilant and pursue not just integrity in that area, but in every area.

Chairman SPRATT. About ten years ago as part of the package deal that became known as the BBA, the Balanced Budget Act of 1997, the package included a sustained growth rate factor. The problem being that when we bore down on rates we tended to see volume increases in the delivery of health care to make up for the

reduction in rates. That has become a problematic ratio these days or equation these days so that for three years in a row or at two years in a row, we have had to correct it, patch it, one year at a time feeling that it would not be fair to administer the kind of cuts that it called for to physicians pay in particular.

We have been waiting on some kind of resolution or correction of that particular formula given the fact that it tends to produce anomalous results. The Administration has indicated in the past that you were working on it, but we have never seen anything. Nobody has seen anything up here and consequently we go from year to year to year correcting the problem. What is your solution to the sustained growth rate factor?

Secretary LEAVITT. Well, first of all, let me just to concur with you, I think it is a lousy system. And I think it is the anytime you have a price setting centrally planned system, you are going to end up subsidizing the wrong things and over charging for others. And in Medicare we make a couple of thousand decisions that begins to drive all the decisions that consumers could make, I think, more wisely and more precisely.

At the root of this problem is the differential pricing where you can go to Mr. Ryan's State in Wisconsin and see a rate that is half what it would be in Milwaukee or rather in Miami. You can't find any difference in the outcomes, but what you will see is that the minute we begin to reduce the rate they just start performing more procedures. There is nothing, there is no competitive or consumer pressure to drive those down and, frankly, that is one of the things that I believe we have got to unleash in Medicare Advantage is that pressure.

Chairman SPRATT. And part of the problem is that conscientious doctors who are not responding by volume increases are nevertheless penalized the same as those who are.

Secretary LEAVITT. Well I—that is what happens in a price setting, centrally planned, government regulated system. And we need to change it.

Chairman SPRATT. Well what is the change then? Surely, you are not talking about privatizing Medicare completely just to get at that particular problem?

Secretary LEAVITT. No, but I, frankly, if we could begin to see part "A" and "B" look a lot more like "D" we would begin to see the impact we have seen on "D." I mean on "D" we started off believing the actuarial—I mean you have got—there were estimates all over the place, but if you figure where it was finally adopted at $37 we are now delivering it for $25. We announced last week, I think, a $247 billion reduction in the original estimate.

Now there are lots of things that go into that, but everyone I know including the government actuaries and any economist that you will find will tell you that a big part of that was competition. We adopted regional competitive environments where in order to get business people had to offer the least possible rate and they had to offer the best possible service. And people had a choice. And we have now seen quality go up and the cost go down.

And so I am—I fundamentally believe that the way we ultimately begin to get at this cost escalation and the way we begin to convert it to a systemic or to a system is that we adopt the same

strategy in part "A" and "B" that we have in "D." And that "D" remains a government regulated but market driven system.

Chairman SPRATT. Well given the situation now, has HHS with Medpack tried to devise, develop a better formula than the formula now in place for the sample growth rate?

Secretary LEAVITT. Well, we welcome the opportunity to work with Congress. It is obviously going to take legislation to do that. If it was just up to HHS I would have come up with something, but at this point it is a matter of legislation and we look forward to working in whatever way. We have got to fix it. We just keep patching it from year to year, I mean from six month to six months. We don't even make a year these days.

So I don't I am not here today to say I have got the formula in my pocket, but it is something worth working on.

Chairman SPRATT. Okay. Thank you very much. Mr. Ryan.

Mr. RYAN. I am going to deviate from what I was actually going to ask, because I thought that line of questioning was quite interesting.

Let me go down this path of looking at ways in which we can reform Medicare to save Medicare. And you showed us the example, Mr. Secretary, of part "D" and how the choice in competition within part "D" actually drove down the projected price.

And let me make sure I just understood what you just said. You are saying that the cost of the program has come in $247 billion lower than the estimate of the program was?

Secretary LEAVITT. If that is the wrong number, it may be $240.

Mr. RYAN. No, I think that is right. I just——

Secretary LEAVITT. Maybe $243.

Mr. RYAN. Okay. So about a 40 percent reduction?

Secretary LEAVITT. Yes. It is a 40 percent reduction.

Mr. RYAN. A 40 percent reduction.

Secretary LEAVITT. And it might be pointed out that we have enrolled 93 percent of those who are eligible in about a year and a half. And 86 percent of them are happy and the 14 percent who are not, have a recourse. They go off and find a plan that they like and they do. They change plans when they are not happy.

Mr. RYAN. Because they are not stuck with the government monopoly. They have choices.

Secretary LEAVITT. Well and we have created a generation of very astute consumers. I can tell you that they have—you know there was scepticism when we started into this, and frankly, a little, people were a little grumpy about it, but they like it now a lot because they have choice. And they have information. And they have driven the quality up and the cost down.

Mr. RYAN. I think that just from a Wisconsin perspective, I held a bunch of these sign up fairs in 2004 with your predecessor and there was a lot of concern, a lot of angst, a lot of just confusion. And we don't see nearly that amount that we did back then. And so it is encouraging to see that a market driven idea which gives the individual choices has actually drive competition, brought cost down, improved quality choice and satisfaction.

I think it is not a huge stretch to say that if we try that idea somewhere else in government it may produce the same results. That is something that is kind of novel, I think, around here but

something we ought to take a look at. And this kind of goes to the heart of the health care debate we are having today.

You mentioned sector versus system. I think it would be roughly the same as saying that we really have a health care market rather than a health care system. And if we systematize health care as some will propose, in your opinion will that make the market more or less efficient? How will that affect patients if we systematize the rest of the health care market in that direction rather than injecting some of these market reforms that involve giving patient more power and choice?

Secretary LEAVITT. We just know at every in every—at every point it is deployed that when consumers have information about quality, when they have information about cost, and they have choice the cost goes down and the quality goes up. We have seen it in nursing homes. We have been able to provide people with information about nursing homes and one thing we find is that when we publish information about the quality and the cost and there is a comparison, we see the quality go up and the cost go down.

Mr. RYAN. One thing that I would like to make an attempt to do, I will reach across the aisle with my democratic friends in the majority. An area that I think we ought to be able to have some consensus on. There is a bill I had with Senator Clinton on this issue and that is the issue of transparency.

We just had the 45 percent trigger triggered. The Minority Leader, the Majority Leader just introduced the bill as required by the law which you sent up the means testing on part "D," I understand that is going to be controversial and I don't know where that is going to go. Medical liability, I understand that is controversial. I don't know where that is going to go. But there is a third, I think people are looking at me telling me where it is going to go. But there is a third element to it which is this transparency aspect. This transparency policy that you produced. The first two I think we all know those save money. You know means testing or income relating—sorry—and medical liability. We know that saves money.

Can you explain to us how and why this transparency initiative, number one, what exactly is it and how and why that can help us save money. And I would like to simply say, humbly, that this is something republicans and democrats ought to agree on. That we ought to be able to work together on this. So if you could just go into that, I would appreciate that, Secretary.

Secretary LEAVITT. Let me just add that in every system that I know of that is a large socialized system outside the United States that most poignant political issue right now is how can we create more choice and also some sense of consumer pressure. And so this is not just something that is about those of us who believe it ought to be conducted in a private way.

There are four cornerstones in my mind to how you create competition based on value. The first is electronic medical records. We have to connect the system. The second is measures of quality. We have to know what quality is in a way that has been agreed upon by the medical family. The third is to have price groupings where ordinary people can understand how much it cost. And then fourth we have got to structure the system so everyone has a motivation to drive quality up and cost down.

Now we are making substantial progress in the area of electronic medical records being able to create standards. We need to drive adoption, but we also need to continue to drive the standards issue. On quality, we have the medical family now working together to develop standards. Actually, I have been in South Carolina and Wisconsin working with local collaboratives that are working to develop measures of quality. We are now getting to the point that those are standardized.

Mr. RYAN. Can I ask you, right there? This is an issue that is difficult to get your hands around, quality, because of risk adjusting and other things. What you will eventually get into these conversations with lets just say replacing a hip and the American College of Orthopedics will say, "Well, you know, replacing Jim's hip or my hip or John's hip is different. You can't measure the quality of these procedures because it is apples to oranges to bananas." Where is the industry able to get an accurate measurement of quality? Number one.

Number two: Do you believe we are getting through a lot of the resistance that we have received lately from the provider community on being willing to submit their data to standard quality metrics?

Secretary LEAVITT. The American Medical Association and many of the and most, maybe I should say all of the professional societies that we are working with that define quality have been extraordinarily helpful. We have formed the Ambulatory Quality Alliance which includes not just the physicians and speciality associations, but also the hospitals, the large payers, the insurance companies and CMS and other government agencies. And we are collaboratively now getting down to the hard job of defining what quality is.

Now, frankly, we are not very good at it yet, but we are getting better and we are getting more and more measures and we are beginning to see this happen. In various places around the country now you can literally get a copy of or you can get a table that will show how many procedures a particular physician performed. How many of them were done at a particular hospital. How many hospital bourne infections that hospital had. Next month Medicare will begin to publish a table on the internet where you can take any hospital in the country on any procedure and determine how much a hospital charged, how much they charged Statewide, and how much the national average and what the patient satisfaction was. We are beginning to know how to do this.

Now we are not at the point we have to be, but when you begin to put those into place, this system can in fact be formed. What we have now is a sector. We have got to systemize it and when we do quality will go up and cost will go down.

Mr. RYAN. Charged. Is that just Medicare charges?

Secretary LEAVITT. Actually, the system at CMS is, however, there are other systems that are beginning to develop. We are weaving a network of what we call chartered values exchanges. We now have 14 of them. I expect by the time we get to the end of the year we will have 30. These are local collaboratives that are using the same standards of quality and the same standards of health information technology to begin to weave into place this system.

Mr. RYAN. And price standards?

Secretary LEAVITT. And price standards.

Mr. RYAN. Okay. Well I could go on and on and on. I don't want to abuse my time. I appreciate it. Who is first over here? Okay. Thank you.

Mr. ALLEN [presiding]. Thank you, Mr. Secretary for being here. I have a comment. I would like to, given more time, get into this philosophical discussion, but I have something more specific I want to deal with. But I did just want to say this: My blood pressure goes up when I read in your description in your testimony that there are two competing philosophies about the role government should play in health care. One is a Washington-run, government-owned plan where government makes the choices, sets the prices, and then taxes people to pay the bills. I don't believe that is a system that, frankly, any of us really expect and want.

Secretary LEAVITT. It is the one——

Mr. ALLEN. The other is supported by the Administration is a private market where consumers chose where insurance plans can compete and where innovation drives the quality of health care up and may drive the cost down.

Now, we are all for electronic medical records. We are all for measures of quality. But based on my experience, talking with my constituents back home, I simply do not believe that price and quality transparency is going to, across the whole range of consumers who are looking for health care, is going to drive them to this miraculous, higher quality, less efficient system. And I didn't really want to get too deep into that.

But let me come to what it looks like to me. It looks to me as if the Administration is simply cutting budgets and letting the States deal with the consequences. The States and all the different people and individuals who are involved. For example, this new the new Medicaid regulations at the Administration has issued. The regulations include changes to targeted case management, rehabilitation, and school-based administration and transportation services.

Taken together these seven new regulations result in cuts of more than $12 billion over the next five years. Now in Maine a lot of this is a direct cost increase to the States. In Maine Governor Baldacci's Office has informed us that these new rules could cost the State of Maine $45 million in the next 16 months. That is one quarter of the deficit that the Governor and the Legislature are struggling with.

I want to focus on the TCM rule, which is scheduled to go into affect on March 3. Just six days from now. That rule would limit the period of coverage for case management services for people transitioning from institutions to the community. It would disproportionately affect individuals with disabilities and mental illness, low-income seniors, and children in foster care.

I have heard from dozens of providers in Maine, including Day One, a substance abuse treatment center; Pen Bay Health Care; Mid Coast Mental Health Center, as well as families with foster children who could have their services cut if this rule goes into affect.

Mr. Secretary, very simply there is a lot of opposition to this rule on the Senate side, there is opposition in the House. You are hearing from the governors of their opposition. Will you delay implementation of this rule?

Secretary LEAVITT. Mr. Allen, Medicaid is a partnership with the federal government and the States. We are all serving the same people. It is a dispute, however, between the partners. And I suspect there is nobody in this room that is in a better position to understand both perspectives than me. I was a governor for 11 years. I think I understand where the States are coming from on this. I have heard from many of them.

But if I could just put this in unvarnished terms, I would like to. There are a number of areas that we have issued rules where we believe that States are using ambiguities in the regulation to unfairly increase our share. And let me explain to you how this works and I know you may know this, but this is driven by consultants who get paid a contingency fee by being able to find any area in the law where there is the breath of some kind of ambiguity. And they have no incentive but to push, push, push, push, push the limits of what should and could be paid for by Medicaid. We have to push back by becoming explicit in eliminating those ambiguities as they happen. And when they do, it is then represented as though we are pushing costs off on to the States.

I am trying to be a steward of the federal position here and I need to be able to push back on occasion when these fee based, contingency consultants find new ways and they have no incentive to do anything else because they get paid. And I need support here, not criticism.

Mr. ALLEN. Well—yeah. But what—but isn't true that you are changing rules some of which have been in place for a considerable number of years. And that the States and the providers and the agencies have come to expect. And you know you may it is not exactly pushing back on something that has just happened recently, from my understanding.

Secretary LEAVITT. Well, lets just take the targeted case management——

Mr. ALLEN. Yes.

Secretary LEAVITT [continuing]. As an example. You don't have to believe me on this, believe GAO. The GAO report itself I mean like two examples. One State, I won't name the States unless you ask me to, hired a contingency fee based consultants. They had $17 million in federal reimbursements according to GAO. They in their audit they concluded that $12 million of the $17 million weren't really eligible but they were pushing the system. Another one had $76 million, three different programs in non-health care agencies.

I mean I will give you an example. This is one that is often cited, schools. I mean none of us disagree with the fact that if there is someone at a school that could be enrolled in Medicaid we ought to have somebody there to help them. Well in reality what they do is they will have a person at the school whose job it is to enroll somebody, but a large percentage of their duties are actually other school duties, but Medicaid pays the entire bill.

Now, if I am a governor and my county is dealing with me in that way, I would not like that, and I don't think the governors would either.

Mr. ALLEN. Well let me just my time is up. I don't really want to extend it, except to make this point: This grows out of the fact that Medicaid is in fact a partnership. And so what we have is the two partners quarreling over who will pay which bill. But the bottom line is that when you pull back on what you have been funding in the past and then you are leaving you are simply moving that burden to the State or to the agencies and you are leaving behind the people you want to help.

I could just as easy, in contrast to the argument you made earlier, I could just as easily make the argument that our system is so complicated, so entwined that we have spent a lot of time, particularly in the private sector and not just the public sector, arguing over who pays the bill and which bills they pay. We have got so much excess bureaucracy built into what, I think you had defined as competition that there may be a piece of the problem that we are really struggling with as a country.

And I——

Secretary LEAVITT. I wouldn't argue that point, because I think you are right.

Mr. ALLEN. I think I better go on or—I know we do. We do. I will withhold and recognize Mr. Garrett.

Mr. GARRETT. I thank you. And I thank the Chairman. Thank you. Thank you, Mr. Secretary.

And to begin I guess I will just follow along some of the line the questioning that was here. During this presidential election, you know, we here so much talk about new medical plans out there, whether we should have a universal health care plan in this country and what the benefits of that would be. And so much of the attack always is saying that the current system isn't working to the degree that the American public wants it to. And that the current system is a market based system and that is what we need to move away from. This goes with some of the argument to a more government controlled central plan.

But help me out with some of the numbers. If you were to take all the people in the country right now who are in Medicare and in Medicaid and other government programs and in the VA and you combine them altogether, what percentage do they make? What percentage of the American public right now is really getting their health care under a government health care system?

Secretary LEAVITT. Well under Medicaid and Medicare combined it would be under 30.

Mr. GARRETT. Yes. And then if you—and as a percentage then out of the population?

Secretary LEAVITT. Under 30 percent. It would be under 30 percent. Is that what you are asking me?

Mr. GARRETT. Under 30 percent?

Secretary LEAVITT. Yes.

Mr. GARRETT. And then you add veterans on top of that?

Secretary LEAVITT. You can get public expenditures if you include all public expenditures——

Mr. GARRETT. Right.

Secretary LEAVITT [continuing]. Indian health, State, federal employees, you can get up to about 39 percent.

Mr. GARRETT. Yeah. About 40 percent. And then on top of that you have the fact that most Americans, if I am not mistaken, you can correct if I am wrong, don't buy their own health insurance they get it through their employer. So if we really talk about a free market based system where I, the patient, have a patient directed health care system, my understanding it is in just the high double digit like 15 some odd percent.

Secretary LEAVITT. It is a very small percentage.

Mr. GARRETT. So the assertion on the other side sometimes that we are in a market based system and that is not working for us and we need to move towards the government control system, the facts really don't support that. We are really already in a government dominated system, isn't that correct?

Secretary LEAVITT. And in order for even those who are employed and have employer based insurance to be part of that market they have to have information about the quality and the cost so they can make judgements on value. That is what is absent now is that none of us have information about what quality is or what cost is and the result is we essentially don't make decisions and the market just continues to go up because we pay on volume——

Mr. GARRETT. Right.

Secretary LEAVITT [continuing]. Not on value.

Mr. GARRETT. Right. And so to go along the lines of Mr. Ryan here, is if you really want to have a patients directed system or a doctor/patient directed system the decision making factor has to be follow the money which would be with the patient then as opposed to the government?

Secretary LEAVITT. That is my view.

Mr. GARRETT. Okay. On another unrelated note with regard to SCHIP. At the end of last year Congress passed and the President signed legislation that extended SCHIP through March of '09. And at that time provided an additional $800 million in funding to cover the so called shortfall States, New Jersey being one of them. Those States that would not have had adequate funding to cover their eligible SCHIP populations.

There was a lot of debate on that. Both Congress and the President rejected proposals to greatly expand SCHIP Program beyond its original intent back then. And yet in the President's budget request now he proposes an additional $2.2 billion in SCHIP spending for fiscal 2009 and $19.7 almost $20 billion over the next five years.

This is a huge increase over his request of just last year. And some of us were standing with the President on his number last year saying that that was the right number. A year goes by and now we are looking at a $20 billion increase at this point.

So my first question is, what happened over that time? And what do you say to those of us who are standing with that number?

Secretary LEAVITT. Well, first of all, thank you. And then second of all, let me reconcile it for you. First of all, the President's number last year was just under $10. We had $5 and then we had $4.8, I believe, of money that had was still in the previous allocations.

The number this year is $19.7, I believe. It is about $10 billion difference.

What we have attempted—the most important change is for us to drop one year and add a more expensive year, which if we are working to develop a policy to fund the policy that is what we would need to do, because we have got a new period.

The second is we have more updated information about the number of children. What we have attempted to do is to take the policy that the Congress passed and put into place a budget that reflects that policy. And the budget numbers reconcile.

Mr. GARRETT. And that is not what the numbers were what the President was trying to do last year when we were throwing out those other numbers then?

Secretary LEAVITT. Well, again, we have better numbers this year than we do last year. And we added on a more expensive year and dropped the less expensive year.

Mr. GARRETT. One last question in my last 12 seconds is this: Is that also in the President's proposal is to provide additional funds to provide greater dollars to the States for outreach purposes to try to bring in the uninsured kids. A report that the HHS came up with shows around 689,000 uninsured children with incomes under the $200,000 level were eligible, but not enrolled in SCHIP.

I guess my question here is, we are already providing an incentive to the States because it is a two to one matching for the States as far the SCHIP Program. That seems to me to be a substantial incentive already for States to do it. Here if you divide the numbers up it is around $450 million over the period of time off the pack of paper it comes down around $100 or $200 per child that you are going to try to bring in.

Aren't we already giving enough incentives to them? Isn't this the States responsibilities to bring them in? And finally, isn't it ultimately the parents responsibility when we already have a federal program to provide free health care to their children that they should be have some responsibility and not the other tax payers to give them additional funds to bull into a system?

Secretary LEAVITT. Yes. Yes. And yes. And may I just say our goal here is to identify those children who are under 200 percent of the poverty level, do our best to enroll them first. And we felt there was a need for us to aggressively do that. I think that was the will of and the policy of Congress and we attempted in this budget to reflect that.

Mr. GARRETT. Okay. Thank you.

Chairman SPRATT [presiding]. Ms. Schwartz.

Ms. SCHWARTZ. Thank you, Mr. Chairman. And I appreciate the opportunity to ask some questions. I had a chance to do that, I guess, a week or so ago at Ways and Means and then did submit some questions for you, so you may know the direction that if you have had a chance to see them, you may know the direction I am going to go in.

And I think I am going to try and find a place where we agree. Okay? We are always looking for bipartisan cooperation here. So I really want to talk about the fact that budgets I do believe are moral documents and there is a great deal of concern about health care and health care costs and how we contain them. I do think we

should start with a goal and I would define the goal very differently than Mr. Ryan does, but I define the goal that under Medicare in particular we are going to try and get quality health care needed by seniors in this country in the most cost effective way possible.

And I agree with you that cuts, particularly across the board cuts, not targeted, not directed, but across the board cuts in Medicare particularly to our hospitals, for example, are not reform. And I agree with you. You just said that and I really do agree with it. But where we do agree, at least rhetorically, is that there are ways that we could make the Medicare system, of payment system, really encourage quality, demand, accountability, and to be able to better assure quality. And we—there are several ways of doing that and you have talked about some of them and certainly so have I.

Electronic medical records.

Secretary LEAVITT. Yes.

Ms. SCHWARTZ. Comparative effectiveness data and distribution of that data. Some of the data you are talking about, but really using that in a very effective way. Encouraging e-Prescribing, which I obviously have a bill on and I would like to see happen. But in fact in the budget, the budget does not reflect those priorities, nor have been the statements from the Administration to encourage that. So we included some of this language, for example, in the legislation that we didn't finally pass, the CHAMP Act. It didn't, we didn't hear from the Administration saying, "Good idea. Lets do that that part of it."

And the fact is that in your budget, in the President's budget, comparative effectiveness research and the agency for Health, Research, Quality is actually cut. So instead of moving in the direction of saying, "Okay. We are not going to just randomly, arbitrarily cut reimbursement, we are going to actually be smart about this. We are going to use technology. We are going to make some investments."

So instead of saying to our hospitals, "We are going to help you do electronic medical records. We are going to help you do e-Prescribing. We are going to reduce errors, demand transparency and accountability. Disseminate the most up to date information possible. Share with you quality at a neighboring hospital you may not know about. And really make it more efficient, more effective, and higher quality." And yet your budget actually cuts those areas.

So I ask it as a question I would like to see these things happen. I think we have an opportunity to do it through Medicare. I think it can be a huge driver towards quality and efficiency and savings, both of lives and of dollars. And then we can save those dollars. That is reform. That is changing the system for the better. It gets health care that we need to people without saying to our hospitals and there are hospitals in my district. They are saying back to me, "Congresswoman Schwartz, you are telling us we should do electronic medical records. We should encourage these things, but in fact under medicare we are getting cut. We have no idea how we are going to make up those millions of dollars."

So can you explain how the rhetoric does not match this budget and does not make the kind of investments that truly can make a difference in both lives and dollars.

Secretary LEAVITT. First, may I say I am pleased about the things we agree on.

Ms. SCHWARTZ. Okay.

Secretary LEAVITT. Second, lets talk about comparative effectiveness. As I recall, this is a big budget, but as I recall the reduction was $9 million.

Ms. SCHWARTZ. Correct.

Secretary LEAVITT. We spend that much at CMS on comparative effectiveness in a week. The fact that that particular line item might have been reduced is likely because we were doing it a lot in CMS and we are doing a lot of it in FDA. So to say that one item was reduced a little and then assume that we don't believe in that as a tenant would not be correct. We have a strong belief in quality and finding ways to do it.

May I address the larger issue you raised?

Ms. SCHWARTZ. Yes. But do follow up on how you could speak to what else you are moving on. I mean I understand we just have this report from the GAO about some of the work that is being done by CMS. It is moving too slowly, basically, according to them. And——

Secretary LEAVITT. I would concur with that. Nothing happens fast enough.

Ms. SCHWARTZ [continuing]. That we need to move much more quickly and much more aggressively to make this happen.

Secretary LEAVITT. Well if we can sign up for more aggressive, I am there. So much of this would be driven faster if consumers had information about what was quality. And where we ought to be investing is in how we can bring together a system that includes the four cornerstones I have spoken of earlier. Our time is up, but this is an engagement I hope we will have on the next——

Ms. SCHWARTZ. Yes. And I know that my time is up, but let me just say this is one that I think we do have to move beyond the rederick. And it is, well it isn't only tools for consumers, but really is also tools for health care providers and hospitals. In Pennsylvania, and you know Pennsylvania some good work on this with the Health Care Cost Containment Council and the Patient Safety Authority and some of the work we are really doing. It is a way for hospitals to look at each other, because really if you are having a heart attack and you are in an ambulance, it is not when you call the Health Care Cost Containment Council and say, "Would you send me that brochure so I can compare which hospital to go to."

It really is the hospitals who are actually saying, "Wait a minute, I don't want to be tenth on the list, I want to be first on the list for quality and efficiency." So it is to just say lets wait until we can get it to the consumers is actually just too far down the line. We really have to use Medicare and use the power of your office and ours, you know, to move this much, much more quickly. And to not just have the same discussion next year and the year after, because then what we are doing is slashing quality and that is not what we want to do, because we are just cutting services arbitrarily rather than where we really know it would not make a difference.

And thanks.

Secretary LEAVITT. Mr. Chairman, would you indulge a 60-second response? In a three month period, starting last month until two months from now, I will be in 40 different metropolitan medical markets, meeting with their medical family, where we have discovered many, I would say more than 100 different groups and communities working to crack the code on quality. And we are working to bring them together and to harmonize standards, not just with quality but an electronic medical records, all of which is aimed directly at this.

Government has a role and it is—and we are working to move this as rapidly as possible. There are some natural barriers to this that we don't have time to talk about today.

Amen. Could you write me down as being for that.

Chairman SPRATT. Mr. Conaway.

Mr. CONAWAY. Thank you, Mr. Chairman. Mr. Secretary, 11 years as a governor, however many years as Secretary of HHS, have you had any experience at all in which an organization you are dealing with, either a State agency or one of your subordinate agencies but then they bill it, that you decided would get less money than they thought they were going to get or actually less money than they got the year before where they thought that was a good idea?

Secretary LEAVITT. No, sir, I have not.

Mr. CONAWAY. Me either.

Secretary LEAVITT. At least seldom.

Mr. CONAWAY. Yeah. I have never come across that yet where that, you know, a legitimate cut which is less money or reduction in the rate of growth wasn't seen as the end of the earth.

We use the word reform in this arena, tolerance, spending, others, and that is a kind, gentle word that has no meaning. I think we have to begin to use the word renegotiate. You are attempting a renegotiation with the States and Medicaid in this arena where they have stretched the original intent of the rules to gain the system in effect with professionals. And whether it is the group, you know, nursing homes or in this instance some other things that you mention, you know, those renegotiations are going to have involve people getting less money than they thought they were going to get or less money than the rate of increase.

And so I just don't think you can have your cake and eat it too in this arena. They are going to have to be as a result of a renegotiations folks are going to get less money. In that regard, can you talk to us any detail that you want on this, it is like the proposal, $113 billion reduction over five years on reimbursements, the premium reform proposal, other kinds of things where you are showing the savings in this entitlement arena on the budget. Just, you know, cuts like that are very dry on the paper. How can what do we expect to actually happen with respect——

Secretary LEAVITT. Well let's——

Mr. CONAWAY [continuing]. As they deal with this?

Secretary LEAVITT. Lets go back to this issue of our relationship with the States, which you know, I have spent a big part of my career thinking the way they are and so I guess it is appropriate that I am now having to deal on the other side of this negotiation. But it has become clear to me that they are, in some cases, driven by

these fee contingency fee consultants who have little to lose from just pushing as far as they can knowing that it may take us years absent this kind of a rule change to beat them back through court.

I mean, for example, States we routinely pay public hospitals a little extra money for a legitimate reason. So States have, through their consultants, have figured out that if you appoint a lot of hospitals as public hospitals you get a little extra money a lot of places. And then they sweep that money up and they put it into their general budget. And that is the money that they use to pay their match.

So they are taking our money and paying our match which we match again. Now that is a very clever approach, but it is wrong. And it isn't a true partnership. And what I am looking for is a partnership where they put up money and we put up real money. Now I understand the need for them to, when I say the need, I understand why they do that. But if I am running a program with integrity, I have to push back, otherwise we have no negotiation here. We have no integrity in our partnership.

And so as I said, I have been I am not surprised by the criticism. I am not surprised by the lobbying campaign. I am not surprised by the fact that we end up with every medical constituency who gets that money and every school district that gets that money and every rehab program that gets that money are somehow coming back saying, "You are cutting services." Well the reality is we are cutting off their staff person who is also doing other things that we are picking up.

And it has been driven by consultants who get paid a portion of it. And there is a lot of criticism of this. But this is good program management that we are doing. And it is saving $18 billion that can go to medical costs for poor people. And that is what it ought to be in.

Mr. CONAWAY. Thank you, Mr. Secretary. I will yield back. Thank you.

Chairman SPRATT. Mr. Doggett.

Mr. DOGGETT. Mr. Secretary, I would like to explore just how good that program management is and the issue of waste, fraud and abuse and just continue the discussion that you and I had two weeks ago this afternoon in the Ways and Means Health Subcommittee.

Just to be fair to you, let me just go back and quote to you my last question to you and your last answer to me. And it was, "I asked last June and again in October, we have submitted it in writing, we have asked it orally, to tell us what happened to the $100 million that you wasted in paying private insurance companies for retroactive coverage for low-income beneficiaries that they were never told about until too late to take advantage of it. I still don't have an answer. The Health Subcommittee doesn't have an answer to it's written questions. Do you think before you come to testify before the Budget Committee this week or next, because we thought it was going to be much earlier the day. When I get a chance to ask you about this again that you could please bring us these answers that have been due since last summer?"

And your answer, Secretary Leavitt, was, "That seems like it would be a smart thing to do."

And my question to you today is, have you done what you said would be the smart thing to do and brought the answers to these eight month old questions?

Secretary LEAVITT. I do not have them with me today. I don't know the status of them.

Mr. DOGGETT. Well, it is incredible. But so is some of your other testimony.

Secretary LEAVITT. They were, Mr. Doggett, provided.

Mr. DOGGETT. Let me ask you about——

Secretary LEAVITT. Just so that——

Mr. DOGGETT. No, sir, they have not been provided to my office as of the beginning of this hearing. If they have been provided it is while you have been testifying.

Secretary LEAVITT. Well, that is not the information I have.

Mr. DOGGETT. Let me ask you about the $150 billion of waste that Chairman Spratt asked you about and the two reasons that you told him not to worry, that we would spend $150 billion in the Medicare Advantage Program.

First of all, this is not a new program. And we have seen year after year, promises like you made today that eventually this was going to save money and year after year we have wasted money on it. We know have the Congressional Budget Office telling us we are about to waste another $150 billion.

And the two explanations why Chairman Spratt and this Committee shouldn't worry about it that you gave were, first of all, that you know if we refine the bidding process it will all go away and it will become a real bargain. I asked you about that two weeks ago whether you or any of our republican colleagues in any of these Committees had ever offered a single legislative proposal to do that. Have you done that in the intervening two weeks?

Secretary LEAVITT. Mr. Doggett, as I told you last year, this program is now three years old and we are at a point where we ought to be looking at some serious——

Mr. DOGGETT. Yes, sir.

Secretary LEAVITT [continuing]. Refinements.

Mr. DOGGETT. Fortunately——

Secretary LEAVITT. And——

Mr. DOGGETT [continuing]. In less than a year this Administration won't be here.

Secretary LEAVITT. Perhaps I could finish my answer, Mr. Doggett.

Mr. DOGGETT. Well you haven't answered. If you will answer, I will let you finish. But the question was have in the last two weeks come up with the legislative proposals that this Administration couldn't come up with in the last seven years? And isn't the answer just simply, no, we haven't done anything?

Secretary LEAVITT. We have not advanced proposals.

Mr. DOGGETT. Thank you for your answer.

Secretary LEAVITT. But it is time for us——

Mr. DOGGETT. Thank you for your answer.

Secretary LEAVITT [continuing]. To be working with the Congress to do so.

Mr. DOGGETT. It is past time. We can agree——

Secretary LEAVITT. And we are very willing to do so.

Mr. DOGGETT. We can agree on that.

Secretary LEAVITT. We are very willing to do so.

Mr. DOGGETT. Now the second——

Secretary LEAVITT. Medicare Advantage is a good thing. It provides——

Mr. DOGGETT. I understand——

Secretary LEAVITT [continuing]. Important benefits.

Mr. DOGGETT [continuing]. You have a——

Secretary LEAVITT. And that is where that money went——

Mr. DOGGETT [continuing]. Strong——

Secretary LEAVITT [continuing]. Was to benefits.

Mr. DOGGETT. And that is my second question. I am glad you touched on that, because that is exactly where I was going.

Secretary LEAVITT. Good.

Mr. DOGGETT. The second excuse that you give to Mr. Spratt about why we shouldn't worry about this wasted $150 billion is well the benefits all go to the beneficiaries, what you were just telling me. And the question that I have for you, sir, is why has your Department refused to require these private insurance companies to notify us of exactly what benefits went where instead of just giving us a little anecdotal evidence. We don't know whether these benefits have been used. We don't know if these benefits have been effective. We don't know if these benefits have been worth a fraction of the $150 billion that we are about to expend on them. Why does the Department refuse to obtain that information?

Secretary LEAVITT. Congressman, your colleagues in the Congress made a decision that they wanted Medicare Advantage as a choice for people to be a national plan. And they have accomplished that in the way that I have described. And it has been a very successful program.

Now in terms of your question——

Mr. DOGGETT. Yes, sir, in terms of my question.

Secretary LEAVITT [continuing]. I am not exactly sure what you are asking. And I would be happy to respond if you want to put it to me in writing so that I can go to my——

Mr. DOGGETT. Well I am not sure you are going to be in office long enough——

Secretary LEAVITT [continuing]. Go to the people who manage the program and ask.

Mr. DOGGETT [continuing]. To answer to it if it is at the same speed as the little $100 million question that I asked you last year that you won't provide us.

Do I understand also, Mr. Secretary, that an answer to Chairman Spratt and the problem that our health care providers, particularly our physicians have all over this country, about how we change the formula under which they are paid that you have no legislation and no ideas how to fix that other than this ideological commitment to privatize Medicare?

Secretary LEAVITT. That is, first of all, no small matter.

Mr. DOGGETT. But you don't have a proposal on how we can provide for a reform of that?

Secretary LEAVITT. I put forward a proposal with respect to that in the Trigger legislation. And I would also suggest to you that while that may not in fact be scoreable in your terms, it will save

money. And I would also suggest to you that it that the solution to the problem of the SGR fix is something that Congress has to fix. I don't have the capacity to do that.

Mr. DOGGETT. Finally, Mr. Secretary, you are aware of the Government Accountability Office report a bipartisan request from Senator Colburn and Senator Carper on improper payments that federal executive branch agencies made last year. Your Department had five of the 14 reports of improper payment. And on two of them you could not even provide a report estimate of when you could tell us how much had been improperly paid.

That was Medicare Advantage and the Medicare prescription drug benefit. Since that came out almost a month ago, do you have any estimate now of when you could estimate how much was wasted on these two programs?

Secretary LEAVITT. That is not information I have.

Mr. DOGGETT. Thank you, sir.

Chairman SPRATT. Mr. Etheridge.

Mr. ETHERIDGE. Thank you, Mr. Chairman. Mr. Secretary, I have a number of questions. I won't read them, I am going to submit them for the record and ask if you will please to respond in writing so that we won't—we have got several votes coming up and it will take an extended period of time and not keep you here.

Secretary LEAVITT. I would be happy to respond.

Mr. ETHERIDGE. Thank you.

Chairman SPRATT. Mr. Scott.

Mr. SCOTT. I had one quick question, if I could. And that is if Medicare could provide the services generally provided under Medicare Advantage for less than the subsidy that we are providing, could we do it better ourselves than this private thing where we have to pay a rebate?

And if you are not prepared to answer that, you can answer——

Secretary LEAVITT. Well I have no way of being able to respond to it in an authoritative way, but I do know this: That whenever we have provided people with choices in a broad enough area, competition has not driven it up, the quality up and the cost down. And I have no reason to believe that that wouldn't happen here too.

Mr. SCOTT. That means you could not provide it cheaper? We have to pay a rebate right now.

Secretary LEAVITT. I am not sure—would you restate your question? I may have answered the wrong question.

Mr. SCOTT. Medicare Advantage we provide a rebate to help the private industries provide the Medicare Advantage. And my question is if we just did it ourselves like we do Medicare, couldn't we do it cheaper?

Secretary LEAVITT. The Congress made a decision to provide enhanced fee for service reimbursement in specific areas so that those who would like to have a Medicare Advantage product could. It was done always with the anticipation that once the program was well in place that adjustments could and should be made in order to bring the reimbursement down not just to the levels equal, but with the anticipation that in some ways it would be some areas it would be below and hence less expensive.

Mr. SCOTT. Okay. Thank you. Thank you, Mr. Chairman.

Chairman SPRATT. Thank you, Mr. Scott.

Mr. Secretary, thank you very much for coming.

Secretary LEAVITT. Thank you.

Chairman SPRATT. We will conclude the hearing with this round of questions, because we have got four votes coming up on—three or four votes coming up on the floor. We don't want to impose upon your time further, but we appreciate your forbearance and your forthright answers to our questions.

Secretary LEAVITT. Thank you.

Chairman SPRATT. Thank you. I ask unanimous consent that members who did not have the opportunity to ask questions of our witness be allowed seven days to submit questions for the record. Without objection, so ordered.

[Questions for the record submitted by Mr. Etheridge follow:]

QUESTIONS FOR THE RECORD SUBMITTED BY MR. ETHERIDGE

1. Mr. Secretary, I understand that you are here to discuss the HHS Budget Request, but I also know that you are a Social Security Trustee and that policies recommended in your budget would affect this important safety net.

a. The President has proposed a health care tax plan that would reduce taxable income for some low-income workers. This would—in the short term—reduce payroll taxes, but would present a problem when the same workers apply for Social Security at retirement. These low-income workers rely heavily on Social Security for retirement income, but the President's plan would reduce their credited earnings and therefore their payments under Social Security. Has the Administration done any analysis of the long-term implications of the Health Care tax proposal for low- and middle-income workers once they reach retirement? Would they be at higher risk of elderly poverty under these plans?

b. Does the President's Social Security privatization plan fix Social Security? If not, what are the long term prospects for Social Security solvency, and what is the President doing to address the issue? Won't workers be at risk of lower Social Security payments under the President's plan? Social Security was designed to be a rock solid guarantee workers can count on, not a risky gamble by Wall Street bankers.

2. The President continues to propose cuts to Medicare and Medicaid that would be devastating to our citizens who depend on the services these public health-care safety nets. These cuts were a bad idea when the President proposed them last year, and the greater cuts in this year's budget are an even worse idea this year when states are already facing financial challenges from the economy.

a. How do you expect states to absorb a $47 billion cut to Medicaid over ten years given the challenges they will face?

b. How do you think the cuts to Medicaid will impact the number of uninsured Americans?

c. Do you think that the cuts to Medicaid will be shifted to providers who serve the low-income families who depend on them, or will Medicare beneficiaries have to pay more out of their pocket?

3. Most the savings in your budget proposal come from cutting payments to hospitals and several other service providers by setting annual payment updates permanently below the level of medical inflation.

a. Is it your opinion that this will motivate providers to be more efficient? Are you concerned that this will instead lead providers to opt out of Medicare and Medicaid entirely, or force them to go out of business as many have, especially in rural areas?

b. One of the biggest cuts in the budget is a three-year freeze on hospital payment rates. Many hospitals already lose money on Medicare. Do you believe that hospitals are overcharging the government for health services? Are you concerned that costs will increasingly be shifted to other payers, or that hospitals will be forced to cut corners in ways that could harm patients?

4. Under current law, doctors will experience a Medicare payment rate cut of 10 percent in June and an additional 5 percent in 2009. Especially in rural areas, medical clinics are closing because they can't afford current payment rates—additional cuts will be devastating. Every year since 2003, Congress has passed—and the President has signed—one-year fixes to prevent physician rate cuts from going into effect.

a. Why isn't the Administration exercising leadership on this issue and presenting ideas for making the physician payment system sustainable for physicians as well as for the budget?

b. Has HHS done any analysis to determine whether these types of cuts can be maintained indefinitely without eventually driving providers out of the Medicare business and harming beneficiaries' access to services?

c. Is the Adminstration doing anything to control the costs of managed care? Why are the physicians bearing the burden of the Administration's budget mess?

[Questions for the record submitted by Ms. Kaptur follow:]

QUESTIONS FOR THE RECORD SUBMITTED BY MS. KAPTUR

1. Mr. Secretary, in December, President Bush signed a bill containing a provision to make research results from the National Institutes of Health available to the public. Congress too has expressed the importance of this provision. Can you please update me on what HHS is doing to support the policy and to ensure that it goes into effect without delay?

2. Mr. Secretary, in an Agriculture Appropriations subcommittee hearing held earlier today, the FDA indicated that this budget will not cover their inspection needs. While the GAO identified that it will take 13 years to complete the backlog of inspections at foreign drug facilities, your budget only asks for three new inspectors. How can you chair an interagency taskforce on food safety and still believe that this budget will protect us?

3. In Ohio, the budget shortfall for its upcoming fiscal year (beginning July 1) is predicted to be as much as $1.9 billion. Unfortunately, this challenge is not unique to Ohio, as more than two dozen states are facing a shortfall. In addition, economic indicators are reflecting significant financial strain on our nation's families: median household income is on the decline, foreclosures are on the rise, and nearly 5 million more people are living in poverty than there were in 2000. Knowing this, why would the President suggest major cuts for important social safety net programs, such as the Social Services Block Grant and the Child Care Development Block Grant?

4. Mr. Secretary, nearly two-thirds of America's hospitals lost money treating Medicare patients in 2006. Both Medicare and Medicaid hospital margins are negative. Why has the Administration called for drastic cuts to Medicare and Medicaid over the next five fiscal years, limiting hospitals' efforts to serve some of its most vulnerable patients?

[Questions for the record submitted by Mr. McGovern follow:]

QUESTIONS FOR THE RECORD SUBMITTED BY MR. MCGOVERN

Question 1: As it has for the past several years, the president's FY 2009 budget proposal cuts the CDC dramatically. Funding for CDC was $6.049 billion for FY 2008 enacted, and the FY 2009 budget request is $5.618 billion. This means CDC core programs are cut by $431.9 million—a reduction of 7.67%.

When taking inflation into account, the reductions are compounded even further. In FY 2005, the CDC's core programs were funded at $6.3 billion—an amount equal to $6.8 billion in today's inflation-adjusted dollars, according to the Bureau of Labor Statistics' consumer price index. Therefore, the budget request for FY 2009 core programs is more than one billion dollars below the CDC's FY 2005 funding, simply taking inflation into account. Such reductions dramatically decrease the purchasing power of CDC programs and have serious, negative repercussions on America's public health programs.

On April 20, 2007, Dr. Julie Gerberding, Director of the CDC, presented a "professional judgment budget" at the request of House Appropriations Committee Chairman David Obey. According to her professional judgment, CDC's core programs required $6.9 billion in funding for FY 2008—more than $1 billion above the current FY 2009 proposed amount.

In addition, the Administration's budget eliminated CDC's Preventive Health and Health Services Block Grant. As the founder and Co-Chair of the Congressional Study Group on Public Health, I find this unacceptable. Of the $97 million eliminated for these programs, $2.7 million is projected to be cut from Massachusetts public health programs. How do you expect states and the CDC to complete its public health mission with these types of eliminations?

Do you, Secretary Leavitt, believe the CDC can sustain a 7.5% reduction in funding and services without damaging the nation's ability to fight disease outbreaks, global viruses, unintentional injuries, and address critical public health trends (e.g. obesity, diabetes, etc.)? Would you, Secretary Leavitt, support Congressional efforts to restore and add more funding to this critical agency?

And finally, Mr. Secretary, if you do stand in support of these reductions, given that the CDC sends nearly 70% of the funds it receives out to state and local health departments, I would like to receive from you in writing how you believe states and localities will need to address the impact your proposed cut will have on our local communities.

Question 2:

1) According to a study by The Commonwealth Fund, Massachusetts ranks highest in the nation on coverage and quality—a result of which we are very proud. Our new health law is an important part of our achieving success, and we appreciate your support in approving our waiver. However, I don't understand your support for these types of state waivers, and your support for a budget that would cut approximately $3.2 billion from our Massachusetts hospitals, home health and skilled nursing statewide providers over the next five years. The loss of these dollars seriously undercuts the ability of Massachusetts' providers to take on the reforms necessary under the new health law. How do you explain the "disconnect" between your support for state health reforms, and the very sizable reductions you propose to Medicaid dollars for the states, and Medicare reimbursements for providers?

ADDITIONAL QUESTION BY CONGRESSMAN MCGOVERN

Mr. Secretary, I am concerned that the National Institutes of Health do not appear to be sufficiently prioritizing research that would develop imaging technologies for prostate cancer detection and treatment comparable to what women currently have for breast cancer detection. I am advised that only a few million dollars were spent last year on this kind of research, even though prostate cancer is an epidemic in our nation and affects one in six American men generally with a disproportionately high mortality rate for African-American men. The National Cancer Institute-funded studies show the frequent ineffectiveness of PSA tests and digital rectal exams, which lead to unnecessary and costly biopsies and surgeries and to unnecessary psychological and physiological complications for millions of American men. One estimate is that digital imaging for prostate cancer detection and treatment could save several billion dollars a year by reducing the number of unnecessary biopsies and surgeries and related hospitalization costs. Women have mammograms, but men don't have a "Manogram." What does your Department plan to do in Fiscal Year 2009 to get us closer to the day when imaging technologies will be developed, manufactured, and accessible to the men in our communities?

[Questions for the record submitted by Mr. Tiberi follow:]

QUESTIONS FOR THE RECORD SUBMITTED BY MR. TIBERI

Mr. Secretary, Medicare covers a number of prostate cancer treatments. Recently, a report from the Agency for Healthcare Research and Quality (AHRQ) has brought to our attention the lack of comparative effectiveness data for prostate cancer. Of the eight prostate cancer treatments, no one treatment emerged as the best option for prolonging life or minimizing side effects. However, Medicare's reimbursement of these various treatments dramatically varies. One treatment in particular is reimbursed at 3-4 times the rate of all the other treatments when considering total episode care costs. Has anyone in your Department examined the discrepancy in reimbursement, especially considering the lack of comparative effectiveness data? And if so, what is HHS doing to create incentives or disincentives, for physicians, hospitals, and Medicare beneficiaries to choose one treatment vs. another?

[Secretary Leavitt's responses to questions submitted follow:]

HHS' RESPONSES TO QUESTIONS SUBMITTED FOR THE RECORD

BOB ETHERIDGE

1. Question. Mr. Secretary, I understand that you are here to discuss the HHS Budget Request, but I also know that you are a Social Security Trustee and that policies recommended in your budget would affect this important safety net.

a.) The President has proposed a health care tax plan that would reduce taxable income for some low-income workers. This would—in the short term-reduce pay roll taxes, but would present a problem when the same workers apply for Social Security at retirement. These low-income workers rely heavily on Social Security for retirement income, but the President's plan would reduce their credited earnings and therefore their payments under Social Security. Has the Administration done any analysis of the long-term implications of the Health Care tax proposal for low and

middle income workers once they reach retirement? Would they be at higher risk of elderly poverty under these plans?

Response: Under current law, the portion of compensation an individual receives in the form of employer-provided health insurance is not included in taxable income for the purposes of either income or payroll taxes. Insurance premiums for individually purchased coverage, on the other hand, are paid with after-tax dollars. SDHI would change the tax treatment of both employer-provided and individually purchased health coverage in a manner that puts both insurance types on an equal footing. For both types of insurance, taxable income would include the insurance premium and would allow a deduction that is initially $15,000 in 2009 and that would be indexed to the CPI in later years. As shown in Table 1, compared to current law, income subject to income and payroll taxes would increase by the cost of the insurance premium (for employer-provided plans) but fall by the deduction for those with employer insurance and for those with individually purchased coverage.

A low-income worker with employer insurance would likely see a decrease in taxable wages in the near term when the insurance premium is less than the deduction. But because medical insurance premiums will almost certainly rise more rapidly than the deduction amount (which increases with the general level of prices), within ten years or so workers would likely see an increase in taxable income relative to current law. Except for older workers near to retirement, lifetime wages subject to Social Security taxes would likely increase, which would cause Social Security benefits to increase.

A low-income worker purchasing coverage on their own would generally have lower Social Security wages in all years under the proposal, although the proposal would allow them the option of rejecting the deduction for Social Security purposes. Taking the deduction for Social Security purposes would cause Social Security benefits to be smaller, but would put a low-wage worker purchasing their own health insurance on an equal footing with an otherwise similar low-wage worker with employer-provided insurance.

Table 1
Current and Proposed Tax Treatment of Health Insurance

	Health Insurance Premium Contribution to Tax Base for Income and Payroll Taxes		
Insurance Type	**Current Law**	**Proposal**	**Change Taxable Income**
Employer Coverage	Excludes value of insurance	Includes insurance value, less flat deduction of $15,000 for family coverage or $7,500 for self only coverage; deduction is indexed to CPI in later years	Increased by value of coverage; reduced by value of deduction
Individual Coverage	Includes the value of insurance	Provide for flat deduction as under employer coverage	Reduced by value of deduction

b.) Question. Does the President's Social Security privatization plan fix Social Security? If not, what are the long term prospects for Social Security solvency, and what is the President doing to address the issue? Won't workers be at risk of lower Social Security payments under the President's plan? Social Security was designed to be a rock solid guarantee workers can count on.

Note: If he claims that most people won't experience a benefit cut because payroll taxes will eventually rise relative to current law because of health care inflation:

c.) Question. Does that mean the President now endorses long term tax increases to extend Social Security solvency?

Response: The President believes that the fiscal health of Social Security is a vital, shared bipartisan responsibility. As the Social Security Trustees' report has noted for several years, the Social Security program is not on a financially sustainable path under current law. The President has repeatedly called for legislation to strengthen Social Security's finances permanently, has offered specific ideas for doing so, and has declared his willingness to consider alternative proposals.

The President has supported personal accounts in Social Security, but has not supported "privatization." Under the President's proposal, Social Security would continue to be administered by the Social Security Administration, as it always has been. The personal accounts themselves would be voluntary; those who prefer to remain wholly under the existing administrative structure and to receive the benefits that it can provide, would be able to do so. Even the proposed personal accounts

would not be "privatized" but would be administered in a structure much like the federal Thrift Savings Plan, which currently adds to the retirement security of employees of the federal government.

The risk of benefit reductions exists in proportion to the amount of further delay until Social Security is financially strengthened. As the President's proposal shows, if we were to act today, we could fully provide promised benefits for today's seniors, without raising taxes, while delivering to future beneficiaries levels of benefits that are higher in inflation-adjusted terms. No one would have a benefit "cut" relative to current levels. If Congress continues to delay action, however, then by the end of the next two presidential terms, that will no longer be the case: at that point, legislators will face tough choices between raising taxes and cutting benefits below the rate of inflation.

2. Question. The President continues to propose cuts to Medicare and Medicaid that would be devastating to our citizens who depend on the services these public health-care safety nets. These cuts were a bad idea when the President proposed them last year, and the great cuts in this year's budget are an even worse idea this year when the states are already facing financial challenges form the economy.

a.) Question. How do you expect states to absorb a $47 billion cut to Medicaid over ten years given the challenge they will face?

b.) Question. How do you think the cuts to Medicaid will impact the number of uninsured Americans?

c.) Question. Do you think that the cuts to Medicaid will be shifted to providers who serve the low-income families who depend on them, or will Medicare beneficiaries have to pay more out of their pocket?

Response: I am deeply troubled that you view the Administration as undermining the healthcare safety net. The Administration shares your concern in protecting the Medicare and Medicaid programs so that they are available for those who need it. The FY 2009 President's Budget seeks to promote fiscal responsibility so that the long-term sustainability of Medicare, Medicaid, and the State Children's Health Insurance Program can be ensured.

I can appreciate that Medicaid is one of the largest programs in State budgets. As Medicaid competes for resources at the State level against all the other demands, an erosion of confidence in the integrity of the Medicaid program is harmful for both Medicaid and for the people who rely on it. The administrative actions we initiated last year will provide greater stability in the program and equity among the States. Each of the rules was vitally important to ensure: the integrity of the Medicaid program; that Medicaid beneficiaries are receiving the services for which Medicaid is paying; that those services are effective in improving the health outcomes of individuals with Medicaid; and that taxpayers are receiving the full value of their dollars that are spent through Medicaid. The Medicaid proposals in the FY 2009 President's Budget further this progress and enhance access and continuity of coverage by improving program integrity, increasing State flexibility, and promoting cost-effective management of Medicaid dollars.

3. Question. Most the savings in your budget proposal come from cutting payments to hospitals and several other service providers by setting annual payments updates permanently below the level of medical inflation.

a.) Is it your opinion that this will motivate providers to be more efficient? Are you concerned that this will instead lead provider to opt out of Medicare and Medicaid entirely, or force them to go out of business as many have, especially in rural areas.

Response: While this Budget proposes a total of $183 billion in savings to the Medicare program over five years, it is important to recognize these numbers in context. Over the next five years, Medicare benefits spending will total $2.8 trillion. The budget proposals only slightly reduce average annual growth in Medicare spending; under this budget Medicare spending will still grow 5 % from FY 2009 to FY 2013, which is a higher growth rate than both the average medical inflation and CPI projections for this time period. In addition, encouraging providers to be more efficient saves beneficiary out-of-pocket costs of $6.2 billion over five years.

The proposed $18 billion in savings for Medicaid are a fraction of the $1.3 trillion in total outlays from FY 2009 to FY 2013. Under this budget, Medicaid spending will still grow by 7.1 % during the next five years.

b.) Question. One of the biggest cuts in the budget is a three-year freeze on hospital payment rates. Many hospitals already lose money on Medicare. Do you believe that hospitals are overcharging the government for health services? Are you concerned that costs will increasingly be shifted to other payers, or that hospitals will be forced to cut corners in other ways that could harm patients?

Response: It is true that Medicare hospital savings in the Budget are the largest for any provider type, but hospitals are also the largest category of Medicare spend-

ing. In fact, other providers will see a similar percentage reduction to their current spending levels. Despite average negative profit margins, hospitals (inpatient and outpatient) continue to have significant access to capital to expand their services. Hospital (inpatient and outpatient) construction spending has grown 191% between 1999 and 2007, with $32.6 billion spent on construction in 2007 alone.

4. Question. Under current law, doctors will experience a Medicare payment rate cut of 10% in June and an additional 5% in 2009. Especially in rural areas, medical clinics are closing because they can't afford current payment rates—additional cuts will be devastating. Every year since 2003, Congress has passed—and the President has signed—one-year fixes to prevent physician rate cuts from going into effect.

a.) Question. Why isn't the Administration exercising leadership on this issue and presenting ideas for making the physician payment system sustainable for physicians as well as for the budget?

Response: Creating some stability in Medicare physician payment levels is important in order to ensure beneficiary access to care. But at the same time, we need to ensure that we are getting the most appropriate value for our expenditures, that quality of care is of the highest levels, and that the fee-for-service payment system doesn't create incentives to generate excess volume and intensity of services.

We do not have a magic bullet to deal with the Medicare physician payment issue. However, we are working on some important elements that could be building blocks that ultimately are part of a revised Medicare physician payment system. We have been implementing the Physician Quality Reporting Initiative (PQRI), which creates payment incentives for eligible professionals, who satisfactorily report quality measures. We are very interested in building on the success of our Physician Group Practice demonstration and incorporating a mechanism for physician group practices to report and perform on quality measures. We are implementing the medical home demonstration project and are interested in the potential for the model to change how care is furnished to and coordinated for Medicare beneficiaries. We are very interested in creating financial incentives to encourage physicians to implement electronic health record systems. We have been working to develop meaningful, actionable, and fair measures of physician resource use to initially be used for confidential feedback reporting to physicians about the comparative costs of their care. As in other payment systems, value-based purchasing and transparency initiatives give consumers access to data that can improve their healthcare choices. We are exploring issues involved with posting the names of physicians who successfully report PQRI measures on the CMS website.

b.) Question. Has HHS done any analysis to determine whether these types of cuts can be maintained indefinitely without eventually driving providers out of the Medicare business and harming beneficiaries' access to services?

Response: We have not done the specific analysis requested. In light of Medicare's longer-term financing challenges, as documented clearly in recent Trustees Reports, our single most important goal is to encourage continued improvement in the efficiency and quality of health care delivered to Medicare beneficiaries, while preserving access to services in a way that is fiscally responsible. Our ability to fulfill the goal of access depends, of course, on continued active participation of physicians in Medicare. Currently, nearly 95 percent of eligible physicians and other practitioners are Medicare participating providers, up from approximately 90 percent in 2004

c.) Question. Is the Administration doing anything to control the costs of managed care? Why are the physicians bearing the burden of the Administration's budget mess?

Response: Regarding the cost of managed care in Medicare Advantage, Congress established current payment levels to ensure that the MA option was available all across the country, including in rural areas. While it is true that MA plans in most regions are being paid more than the FFS rates, the vast proportion of the extra amounts are required to go directly to beneficiaries in the form of reduced cost sharing or extra benefits. Because of these policies, beneficiaries in all parts of the country have access to at least one Medicare Advantage plan. The Administration continues to support policies that will ensure all beneficiaries across the country have access to these plans.

Medicare Advantage (MA) rates are tied to fee-for-service rates, therefore, the proposals to reduce spending in traditional Medicare will also reduce MA payments. Nearly 25 of the proposed Medicare savings in the Budget will be borne by managed care plans.

JAMES MCGOVERN

1. Question. As it has for the past several years, the president's FY 2009 budget proposal cuts the CDC dramatically. Funding for CDC was $6.049 billion for FY 2008 enacted, and the FY 2009 budget request is $5.618 billion. This means CDC core programs are cut by $431.9 million—a reduction of 7.67%.

When taking inflation into account, the reductions are compounded even further. In FY 2005, the CDC's core programs were funded at $6.3 billion—an amount equal to $6.8 billion in today's inflation-adjusted dollars, according to the Bureau of Labor Statistics' consumer price index. Therefore, the budget request for FY 2009 core programs is more than one billion dollars below the CDC's FY 2005 funding, simply taking inflation into account. Such reductions dramatically decrease the purchasing power of CDC programs and have serious, negative repercussions on America's public health programs.

On April 20, 2007, Dr. Julie Gerberding, Director of the CDC, presented a "professional judgment budget" at the request of House Appropriations Committee Chairman David Obey. According to her professional judgment, CDC's core programs required $6.9 billion in funding for FY 2008—more than $1 billion above the current FY 2009 proposed amount.

In addition, the Administration's budget eliminated CDC's Preventive Health and Health Services Block Grant. As the founder and Co-Chair of the Congressional Study Group on Public Health, I find this unacceptable. Of the $97 million eliminated for these programs, $2.7 million is projected to be cut from Massachusetts public health programs. How do you expect states and the CDC to complete its public health mission with these types of eliminations?

Do you, Secretary Leavitt, believe the CDC can sustain a 7.5% reduction in funding and services without damaging the nation's ability to fight disease outbreaks, global viruses, unintentional injuries, and address critical public health trends (e.g. obesity, diabetes, etc.)? Would you, Secretary Leavitt, support Congressional efforts to restore and add more funding to this critical agency?

And finally, Mr. Secretary, if you do stand in support of these reductions, given that the CDC sends nearly 70% of the funds it receives out to state and local health departments, I would like to receive from you in writing how you believe states and localities will need to address the impact your proposed cut will have on our local communities.

Response: The Preventive Health and Health Services Block Grant (PHHSBG) has served as a flexible resource supporting state and local prevention efforts. CDC has funded 61 grantees, including all 50 States, the District of Columbia, 8 Pacific Island territories, and 2 Native American Indian tribes. Because of the difficulty in establishing consistent measures for a flexible program like PHHSBG, there are limited national outcome data on a consistent set of measures across all states. PHHSBG was created more than two decades ago as a means to consolidate multiple categorical grants in place at the time. Since its creation, a number of categorical grants have emerged that address some of the same public health issues. In the main areas covered by the PHHSBG, CDC categorical programs are now funded at $800 million a year. As a nation, we face difficult decisions in prioritizing how we use the scarce resources available to meet the overwhelming needs in health as well as other areas. As CDC strives to improve efficiency and effectiveness, existing programs will continue to be available to address many public health issues traditionally covered by the Block Grant.

2. Question. According to a study by The Commonwealth Fund, Massachusetts ranks highest in the nation on coverage and quality—a result of which we are very proud. Our new health law is an important part of our achieving success, and we appreciate your support in approving our waiver. However, I don't understand your support for these types of state waivers, and your support for a budget that would cut approximately $3.2 billion from our Massachusetts hospitals, home health and skilled nursing statewide providers over the next five years. The loss of these dollars seriously undercuts the ability of Massachusetts' providers to take on the reforms necessary under the new health law. How do you explain the "disconnect" between your support for state health reforms, and the very sizable reductions you propose to Medicaid dollars for the states, and Medicare reimbursements for providers?

Response: The FY 2009 Budget proposes to reform and transform the health care system by allowing States the opportunity to craft innovative solutions to provide people access to affordable insurance. The Budget complements existing State efforts with policies that would expand the use of high risk insurance pools and subsidize the purchase of private insurance for low-income individuals.

While the Budget proposes a total of $183 billion in savings to the Medicare program over five years, it is important to recognize these numbers in context. Over

the next five years, Medicare benefits spending will total $2.8 trillion. The budget proposals only slightly reduce average annual growth in Medicare spending; under this budget Medicare spending will still grow 5 % from FY 2009 to FY 2013, which is a higher growth rate than both the average medical inflation and CPI projections for this time period. In addition, encouraging providers to be more efficient saves beneficiary out-of-pocket costs of $6.2 billion over five years.

The proposed $18 billion in savings for Medicaid programs are also a fraction of the $1.3 trillion in total outlays from FY 2009 to FY 2013. Under this budget, Medicaid spending will still grow by 7.1 % during the next five years.

It is true that Medicare hospital savings in the Budget are the largest for any provider type, but hospitals are also the largest category of Medicare spending. In fact, other providers will see a similar percentage reduction to their current spending levels. Despite average negative profit margins, hospitals (inpatient and outpatient) continue to have significant access to capital to expand their services. Hospital (inpatient and outpatient) construction spending has grown 191% between 1999 and 2007, with $32.6 billion spent on construction in 2007 alone.

The home health proposal is consistent with the Medicare Payment Advisory Commission's (MedPAC) recommendation during the January 2008 meeting that home health agencies receive a 0% update in 2009. MedPAC estimates that Medicare margins for home health agencies averaged 15.4% in 2006 and will reach approximately 11.4% in 2008. Further, MedPAC analysis shows that the number of home health agencies continues to grow, as does the volume of services provided. At the same time, quality of care is improving, and cost growth remains low. A 0% update for 2009 through 2013 would encourage program efficiency without affecting the ability of home health agencies to furnish high quality care to Medicare beneficiaries.

Spending on SNFs continues to increase, with an increasing volume of services provided, and beneficiaries having few problems accessing SNF care. The proposed 0% update for FY 2009-2011 would encourage program efficiency without affecting the ability of SNFs to furnish high quality care to Medicare beneficiaries. This proposal is consistent with recommendations made by MedPAC for 2009 and builds upon these recommendations for future years. MedPAC estimates SNF Medicare margins averaging 11.4 % in FY 2008. This proposal would also strengthen the long-term financial security of Medicare, which is critical to stability in access as well as quality.

3. Question. Mr. Secretary, I am concerned that the National Institutes of Health do not appear to be sufficiently prioritizing research that would develop imaging technologies for prostate cancer detection and treatment comparable to what women currently have for breast cancer detection. I am advised that only a few million dollars were spent last year on this kind of research, even though prostate cancer is an epidemic in our nation and affects one in six American men generally with a disproportionately high mortality rate for African-American men. The National Cancer Institute-funded studies show the frequent ineffectiveness of PSA tests and digital rectal exams, which lead to unnecessary and costly biopsies and surgeries and to unnecessary psychological and physiological complications for millions of American men. One estimate is that digital imaging for prostate cancer detection and treatment could save several billion dollars a year by reducing the number of unnecessary biopsies and surgeries and related hospitalization costs. Women have mammograms, but men don't have a "Manogram." What does your Department plan to do in Fiscal Year 2009 to get us closer to the day when imaging technologies will be developed, manufactured, and accessible to the men in our communities?

Response: To identify prostate cancer at an earlier stage through specialized and targeted imaging, screening and detection methods, the National Cancer Institute (NCI) is funding numerous grants and other research initiatives. These efforts aim to develop tools including in-vivo models (animal and human) for molecular imaging and analysis; imaging tracers; in-vivo image-guided therapy using multi-modal imaging approaches; imaging methods to provide metabolic assessment of the presence and extent of human prostate cancer; and combinations of imaging with emergent technologies such as nanotechnology, genomics, proteomics and high-throughput screening.

Novel imaging techniques and therapies being explored include: advanced ultrasound devices, portable imaging devices to detect prostate cancer, nuclear magnetic resonance (NMR) imaging, superconducting quantum interference device (SQUID) imaging, gene-based imaging and therapy to target metastatic prostate cancer, morphologic, metabolic and functional prostate imaging, metabolic imaging using 3-D magnetic resonance spectroscopic imaging (MRSI), PET imaging using oncogenic approaches, and advanced quantitative image analysis techniques. Image-

guided cancer therapy is a rapidly evolving area that may provide more effective and efficient treatment methods through minimally invasive techniques.

With the advent of a better understanding of cell and biological processes at a molecular level coupled with the development of new biological reagents and probes, and recent developments and improvements in imaging technology, it is appropriate to focus attention on bringing together these advances. The NCI is facilitating preclinical and clinical multi-disciplinary research on cellular and molecular imaging related to cancer through In vivo Molecular Imaging Centers (IMIC) supported by Specialized Programs of Research Excellence (SPOREs) grants.

NCI also works with The American College of Radiology Imaging Network (ACRIN), the cooperative group which serves as a multi-institutional platform for conducting phase II and III clinical trials in screening, diagnosis, staging, response to therapy and image-guided therapy. A clinical trial studying 134 participants with biopsy-proven prostate adenocarcinoma evaluated the accuracy of combined magnetic resonance imaging (MRI) and magnetic resonance spectroscopic imaging (MRSI) performed at 7 institutions in the localization of prostate cancer and its incremental benefit on diagnostic accuracy when compared to MRI alone, and found no overall improvement in accuracy. The NCI-sponsored Development of Clinical Imaging Drugs & Enhancers (DCIDE) program competitively expedites and facilitates the development of promising investigational imaging enhancers (contrast agents) or molecular probes from the laboratory to Investigational New Drug (IND) status.

In addition to developing new imaging technologies, NCI is also aware that new tools and techniques for prostate cancer detection need to be made available to patients in their local communities. NCI efforts are underway to address racial disparities in prostate cancer incidence and mortality rates. The Southern Community Cohort Study (SCCS), which expects to enroll 90,000 participants in 12 states, is examining why prostate cancer rates are higher in African American men.

MARCY KAPTUR

1. Question. Mr. Secretary, in December, President Bush signed a bill containing a provision to make research results from the National Institutes of Health available to the public. Congress too has expressed the importance of this provision. Can you please update me on what HHS is doing to support the policy and to ensure that it goes into effect without delay?

Response: NIH implemented Division G, Title II, Section 218 of Public Law 110-161 on January 11, 2008 (*http://grants.nih.gov/grants/guide/notice-files/NOT-OD-08-033.html*). As of April 7, 2008, applicable manuscripts arising from NIH funds must be submitted to

PubMed Central upon acceptance for publication. As of May 25, 2008, NIH applications, proposals, and progress reports must include the PMC reference number when citing a manuscript that falls under the Public Access Policy. NIH has developed a website (*http://publicaccess.nih.gov/*) with training materials and frequently asked questions. In addition, NIH is in the midst of a communications effort that includes in-person trainings, news articles, and other outreach efforts. Finally, NIH sought formal comments on the Public Access Policy and its implementation. It also held an open meeting for stakeholders on March 20, 2008, and issued a 60-day Request for Information later in March 2008. All comments collected are publicly available at *publicaccess.nih.gov/comments.htm.*

2. Question. Mr. Secretary, in an Agriculture Appropriations subcommittee hearing held earlier today, the FDA indicated that this budget will not cover their inspection needs. While the GAO identified that it will take 13 years to complete the backlog of inspections at foreign drug facilities, your budget only asks for three new inspectors. How can you chair an interagency taskforce on food safety and still believe that this budget will protect us?'

Response: FDA has developed a comprehensive Food Protection Plan to address the changes in food sources, production, and consumption in response to today's challenges. The Food Protection Plan presents a robust strategy to protect the nation's food supply from unintentional contamination and deliberate attack. The President's Budget for FDA requests an increase of $42.2 million for FDA's implementation of the Plan's risk based strategies to ensure the safety of domestic and imported food and feed. In addition, the budget supports establishing an FDA presence overseas in China and in other countries, provides for over 1,000 additional inspections and 20,000 additional import field exams, enhances emergency response capabilities, and develops new tools to detect and quickly identify risk signals and expand FDA's risk based surveillance.

3. Question. In Ohio, the budget shortfall for its upcoming fiscal year (beginning July 1) is predicted to be as much as $1.9 billion. Unfortunately, this challenge is not unique to Ohio, as more than two dozen states are facing a shortfall. In addition, economic indicators are reflecting significant financial strain on our nation's families: median household income is on the decline, foreclosures are on the rise, and nearly 5 million more people are living in poverty than there were in 2000. Knowing this, why would the President suggest major cuts for important social safety net programs, such as the Social Services Block Grant and the Child Care Development Block Grant?

Response: The President's FY 2009 budget maintains significant investments in programs that provide critical services to children and families while at the same time taking a responsible approach to deficit reduction.

In fact, the budget request includes increases in funding for key investments in programs serving children and families, such as the Adoption Incentives Program (request of $19.7 million is over $15 million more than the FY 2008 enacted level), the Mentoring Children of Prisoners program (request of $50 million is $1.4 million more than the FY 2008 enacted level), and Head Start (request of $7 billion is $149 million more than the FY 2008 enacted level).

The Administration recognizes the importance of child care and has recommended continued funding of the CCDBG at $2.1 billion. In addition, Federal and State funding for child care is at an all time high and has increased more than threefold between 1996 and 2008, from approximately $3.6 billion to $12 billion. This includes the increase in Federal child care funding enacted by the Deficit Reduction Act of 2005 (DRA), which totals $1.8 billion in new funding through FY 2010 when factoring in State matching funds. Also, States have numerous funding streams that can be used for child care, and they have maximum flexibility to maintain coverage for needy families. By design, the Child Care and Development Fund (CCDF) block grant is not the only source of Federal support for child care. For instance, States may transfer up to 30% of their TANF funds to CCDF, or spend TANF directly on child care without limit.

Finally, it is important to understand that there are a number of other programs including Head Start, State funded Pre-K, and the 21st Century Community Learning Centers, that are providing quality care for children who otherwise might be in need of child care services during the hours they attend those programs.

At the same time, however, the Administration is committed to deficit reduction and consequently the budget targets resources to those programs with measurable outcomes and applies funding reductions to programs that have failed to demonstrate results, like the Social Services Block Grant.

4. Question. Mr. Secretary, nearly two-thirds of America's hospitals lost money treating Medicare patients in 2006. Both Medicare and Medicaid hospital margins are negative. Why has the Administration called for drastic cuts to Medicare and Medicaid over the next five fiscal years, limiting hospitals' efforts to serve some of its most vulnerable patients?

Response: It is true that Medicare hospital savings in the Budget are the largest for any provider type, but hospitals are also the largest category of Medicare spending. In fact, other providers will see a similar percentage reduction to their current spending levels.

Despite average negative profit margins, hospitals (inpatient and outpatient) continue to have significant access to capital to expand their services. Hospital (inpatient and outpatient) construction spending has grown 191% between 1999 and 2007, with $32.6 billion spent on construction in 2007 alone.

In addition, while this Budget proposes a total of $183 billion in savings to the Medicare program over five years, it is important to recognize these numbers in context. Over the next five years, Medicare benefits spending will total $2.8 trillion. The budget proposals only slightly reduce average annual growth in Medicare spending; under this budget Medicare spending will still grow 5 % over FY 2009 to FY 2013, which is a higher growth rate than both the average medical inflation and CPI projections for this time period.

The proposed $18 billion in savings for Medicaid are a fraction of the $1.3 trillion in total outlays from FY 2009 to FY 2013. Under this budget, Medicaid spending will still grow by 7.1 % over the next five years.

PATRICK TIBERI

1. Question. Mr. Secretary, Medicare covers a number of prostate cancer treatments. Recently, a report from the Agency for Healthcare Research and Quality (AHRQ) has brought to our attention the lack of comparative effectiveness data for prostate cancer. Of the eight prostate cancer treatments, no one treatment emerged

as the best option for prolonging life or minimizing side effects. However, Medicare's reimbursement of these various treatments dramatically varies. One treatment in particular is reimbursed at 3-4 times the rate of all the other treatments when considering total episode care costs. Has anyone in your Department examined the discrepancy in reimbursement, especially considering the lack of comparative effectiveness data? And if so, what is HHS doing to create incentives or disincentives, for physicians, hospitals, and Medicare beneficiaries to choose one treatment vs. another?

Response: There are a number of treatment options for prostate cancer depending upon the beneficiary's individual clinical situation, physician input and beneficiary preferences. These options can be delivered in any number of settings, and the costs associated with delivering these treatment options can vary based on the complexity of the procedure and the patient's individual clinical circumstances. We have not examined the total episode care costs for the different prostate cancer treatments in the different settings in which these treatments are furnished.

As with Medicare payment for all services, Medicare pays for different prostate cancer treatments under different payment systems depending on the site in which the services are furnished. Payment rates are established under each Medicare payment system generally based on the relative costs or typical resources involved in furnishing services.

[Whereupon, at 3:15 p.m., the Committee was adjourned.]

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